Exam date 22nd april 2018 Centre kolkata india Alhamdulillah i have passed my paces.

Station 1: respiratory: ILD with rheumatoid hand. Abdomen: hepatospleenomegaly with anaemia and jaundice.

St 2: young female with one episode of loss of consciousness with seizure and loss of urinary control.she had family history of epilepsy.it was vaso vagal attack.concern about drving.

St 3:cardio: AS with AR with MS.difficult one.

Neuro: spastic paraparesis with absent ankle jerk with intact sensory.

St 4: steveven johnson syn in wife who got penicillin during NVD.baby is ok.talk to husband.task explain it and tell him that she will be shifted to ICU and may require ventillation. I started with asking about the family support, condition of the baby and any need of financial help.then explained the grave condition of the wife in simple words.his concern was why this happened,will she survive or not,what to do about the baby.

Bcc1:female patient known diabetic for many years came with vision problem. On fundoscopy there was

grade 3 hypertensive retinopathy.patient was not aware of her hypertension.

Bcc 2: male pt with DM.came with pain in the thigh.on examination there was loss of sensation over the lateral aspect of thigh.i said Meralgia parasthetica due to damage of lateral cutaneous nerve of thigh.sor asked about D/d Diabetic neuropathy,radiculopathy,any form of myositis.

paased MRCP PACES from kolkata,India, My exam started with history taking it was vago vagal syncope, Abdomen hepatosplenomegaly, jaundice with anemia probably hemolytic anemia,

CVS....Mitral valve replacement,

Respiratory RA with ILD,

Neurology Spastic paraplegia without sensory impairment with scar mark in thoracic spine area, communication drug reaction,

BCC1 DM with retinopathy,

BCC2 DM with meralgic perasthetica.

passed from Kolkata Centre, 21st April, second carousel ▲
✓ Station.2 ▼ ☞ - Analgesic misuse HA with underlying migraine + family problem.

✓ Station.4 ▼ ☞ - Hepatic encephalopathy, alcoholic, developed hepato-renal $. Consultant decided not to do transplant. Talk to son about this and also discuss resuscitation status.

✓ BCC 1 ▼ ☞ - Young man c/o joint pain. Has congenital heart disease. Gout precipitated by diuretics.

✓ BCC 2 ▼ ☞ - c/o SOB. Inside : ankylosing spondylitis.
✓ CVS ▼ ☞ - c/o SOB. Mitral valve replacement. ✓ CNS ▼ ☞ - c/o difficulty in walking. Lt sided hemiplegia (+Lt. facial palsy)

✓ Resp ▼ ☞ - Rheumatoid lung

✓ Abdomen ▼ ☞ -✓ Abdomen ▼ ☞ - jaundice with ascites.

KOLKATA BCC COLLECTION
1.30yr old gentleman with uncontrolled hypertension. Uncontrollable BP for 1 year with enalapril, atenolol, water pills. Wt -60kg. No hyperthyroid symptoms. No renal/CVS/CNS symptoms. Smoked previously for 10yrs. Drink alcohol. Mother has hypertension. No AF, murmur. Unequal pulse +. No renal bruit. Dx… Takayasu's arteritis.
2. 28 yes old lady, regular attender in asthma clinic. Today presented with acute breathlessness.

Salbutamol inhaler for asthma. Pain in lt calf. Travel to Switzerland 12 hrs flight last week. OC pills +. DVT + in mother. No history of miscarriage. Physical examination normal. Dx.. PE Ex: dx. Invx. Which blood test will you do in suspected PE? Can you exclude PE if Doppler is negative.

3.60yr old gentleman had dyspnoea for five months. He had back pain for 3 years. Ankylosing spondylitis patient taking celecoxib and ibuprofen comes with SOB for 5 months. Smoking +. AS features +. Chest wall expansion reduced. Ht and lungs normal. Concern: what's wrong? Come back to normal? Dx: chest wall deformity and reduction in chest wall expansion in AS patient

Ex: findings in lungs and heart? Causes of SOB in AS patient? Invx? Mgt?

4. Know RA patient comes with SOB. RA hand deformity +. Lungs basal crepts +. Dx: pulmonary fibrosis

5. 23 yrs old lady with weakness of rt side of body. Weakness of rt side of body and slurred speech comes suddenly while having breakfast. 30 mins last. Blurred vision +. Facial weakness +. Claudication pain + when using arm repeatedly. BP 140/90 rt arm, 130/80 Lt arm. Taking amlodipine for hypertension. Dx: Takayasu arteritis.

6. 40 yrs old gentleman comes with sudden weakness of rt half of body. Transient weakness of rt side of body, cardiac operation done 5 yrs ago for coronary angioplasty. Very slow AF+. Dx: TIA.

7. DM patient presenting with Loss of vision and Rt sided weakness.
8. 70yrs old man with Ht problem presenting with weakness of lt side of body with slurred speech and completely recover at 10 mins. AF+. MDM+.
9. 26 yrs old lady with painful legs. Wt gain +. Missed period for 2-3 months. Concern: serious? Curable? Dx: Meralgia paresthetica
10. 50 yrs old gentleman comes to you with episodic diarrhoea. Flushing +. Wheezing +. Diarrhoea +. Dx: Carcinoid syndrome.
11. Know DM patient presenting with weight loss. Dx: Thyrotoxicosis.
12. Known asthma patient presenting with palpitation. Rt eye exophthalmos ? Thyrotoxicosis.
13. 57 yrs old lady referred from DM clinic for difficult control of blood sugar level. Topical steroid use for skin infection. Herbal medicine for 4 months. Concern: why sugar level difficult to control. Dx: Cushing syndrome.
14. 54 yrs old gentleman who is a regular attender in diabetes clinic for 20 yrs. He was referred for tingling sensation of both hands. Dx: carpal tunnel syndrome with goiter.
15. 38 yrs old lady complaint of painful hands. Dx: Peripheral neuropathy
16. % Hand Pain
Dx: RA
17. 60 yrs old lady in surgical ward admitted for hemorrhoids now complaining of joint pain of forehands and back pain. Deforming polyarthropathy

with back pain No skin rash. Fever present for months. Concern: infection? Disease activity?
18. Outside. 35 years old female vision problem and headache Inside. Bumping into Rt side. No blurring. No double vision Headache. Generalized. No photpphobia.no lacrimation.no wt changes. No OC pills. No ICP.no acromegaly feature. No past medical and surgical.no similar attack No symptom of GCA.no pit tumor O/E. Pronator normal.v acuity normal. V.field.rt HH .Fundus normal Ex asked finding and lesion side
I said optic tract. Optic radiation.occipital
19. Outside progressive SOB and swallowing difficulty Inside . Systemic sclerosis No LOW.no Loa. No dysphagia. Only got heartburn Surrogate didn't tell medical history But i asked medication . She said PPI. Cyclosporin. Prednisolone Lung .clear
20. sudden loss of vision in rt Eye kco bicuspid aortic valve
21.an elderly gentleman who had sudden loss of vision of his right eye. K/c/o HTn under Amlodipine. Had CABG scar on chest and leg scars too. Did ask all relevant questions and examination. Looked at fundus. Found it very red. When I asked 'Do you have any concerns?' he didn't understand. He was an old Bengali **man. The examiners gave him some clues and he**
asked me "Questions?" I said 'Yes'. He said 'Yes Yes. I have questions for you. Number 1. **What is wrong? Number 2 Is it permanent? No 3** What can

you do?’ Said Vitreous Hemorrhage **or retinal detachment. Missed to say CRVO. Was so so so tensed there.**

22.There was an English patient with swelling of his Left lower limbs. Was a DVT. It was unprovoked and he was on Aspirin. No h/o any surgeries or travel. No features of malignancies. He was a priest. They asked normal questions on DVT.

23.MS - rt hemianopia with optic atrophy with h/o rt sided weakness

24.? Ankylosing with ILD/COPD - wheezes as well as crepts - little odd

25.psoriatic arthritis

26.first episode of seizure in 55 years old

This is my experience ; I passed from Kolkata Centre, 21st April, second carousel.

St.2 - Analgesic misuse HA with underlying migraine + family problem.

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CNS - c/o difficulty in walking. Lt sided hemiplegia (+Lt. facial palsy)

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BCC 1 – Young man c/o joint pain. Has congenital heart disease. Gout precipitated by diuretics.

BCC 2 – c/o SOB. Inside : ankylosing spondylitis. Resp – Rheumatoid lung

Abdomen – jaundice with ascites.

My experience..i think that will help other.i have passed from diet 3..Kolkata centre's Exam started with

St 2: APS 2 Most horrible part of my exam bcz I appear 1st time with 1st station.

St3 Cvs: MVR with AF with pAH Examiner was very happy with my performance he thumb up &said best of luck Dr for exam I was inspired 20/20

CNS: Spastic para paresis Dx,mx.inx.rx 19/20

St 4: Mx of angry son due penicillin allergy 12/16

St 5 Bccc1 RA with ILD Got 28/28

Bcc 2 Gout28/28

St 1 Abdomen CLD with Hepatomegaly Examiner ask lots of questions Got 19/20 Respiratory ILD Inv.mx.rx.dd 16/20 Grateful to ALLAH.. I

Kolkata (India)
🔹Station 1 ✓ Resp RA hand with COPD Pleural effusion
✓ Abdomen Alcoholic Liver Disease with Ascites Upper abdominal scar (Thalassaemia+Splenectomy)
🔹 Station 2 Swelling of face and tongue (Angioedema)
✓ Station 3 🔹 CVS CABG with MR ? Normal Heart
🔹 CNS Spastic paraparesis with scar at back Right homonymous hemianopia (Stroke)
🔹 Station 4 Young lady presents with Seizure and Right Temporal abnormality on CT head, Neurosurgeon wants to do MRI for confirmation (Epilepsy) Explain about uncertainty of diagnosis and MRI ✓ Station
✓ Station 5 🔹 BCC 1 : RA with ILD
🔹 BCC 2 : Sudden loss of vision (CRAO) with Biscuspid aortic valve disease

my experience kolkata on 24.11.17.
st5) pt with SOB for 6 months, inside I found pt with RA with hand deformity taking MTx for 5yrs. I got bilateral basal creps, anaemia, lots of concerns to answer
st5) pt with sudden loss of vision for last 3days with a pt with congenital bicuspid aortic valve, inside rt sided complete loss of vision with mydriasis, pale

optic disc. I said could be clot in the vessel, dd was MS,
st1) bilateral basal creps with rheumatoid hand asked dd ild, heart failure, bronchiectasis

st1) cld with tattoo, flapping tremor,rigid abdomen asked lot about investigation

st2) hereditary angioedema, asked about dd

st3) CABG, saphenous vein graft scar with systolic murmur, splitted 2nd HS, I said ASD but may be MR
st3) Cranial nerve examination, I found rt sided homonymous hemianopia, asked about causes :stroke,MS, ICSOL I told wanted to know detail about interpretation of visual evoked potential test

st4) explining about the uncertainty of CT report with a pt with seizure. need further MRI. this was very easy but I didn't read the scenerio throughly as it was long and I was exhausted. I just told you have brain tumor and need MRI to confirm that. ..... examiners were very angry about my communication. I will get 0 in this station. . . ALLAH IS KIND, ALMIGHTY. if he wants, i will pass only.

started rapidly and this time I tried to form a group, so I was shifted to rented house and some of my other exam gong friends actively participated in group discussion and seeing cases together. This actually helped a lot and I regained my confidence. I have

6.4.2017 (1st round) Sundaram Resp: c/o: SOB rt lower lobe bronchietasis
Abd: C/O: abd discomfort AV fistula with hepatomegaly
CVS.. MR: apex beat not displaced heaving, systolic murmur at mitral area Complaint.. chest pain
CNS: C/O: difficulty in walking examine neurological system

Parkinson History: chest pain: vauge pain, st worse with meal but cant relieve with antacid. SOB+. Strong family history of ht attack in father and brother. Ex smoker. Hypercholesterolemia

+. Comm: BBN meningococcemia

Bcc: neck swelling.. simple goitre euthyroid : hypertension, temi pain and hamaturia: PKD. (pt: normal).

Exam Experiences(of my Dear Brother) -Kolkata - India April 2017
St2 changle in bowel habbit for 6 months gp prescribed mebeverine no improvement. Analysis of complaint large volume diarrhea 500ml for 5 times(small intestine pathology) no blood no slim no relation to food no improvement after fasting awake him at night with urge to move bowel vague abdminal pain ,wt loss not significant. Pmh of joint surgery, Travel history last year. What is your dx?ibd Your dd ibs , caeliac,tropical sprue,cancer,hiv . Invs?basic,stool,antibodies

screen,faecal calprotectin,endoscopy ,cancer markers? Which antibodies to order?iga,ttg,ema
St3 Cardio Mid sternotomy scar ,harvest graft ,no metallic ,systolic murmur at apex. Dx MR,PHT Invs,ttt

Neurology examine cranial nerves Right Homonymous Hemianopia Causes?leasion beyond chiasma tract ,radiation,occipital lobe,pisterior cerebral artery occlusion,internal capsule. Causes?invs?

St4 SAH on warfarin inr 4 with large onfarcts specialist see no benefit from surgery talk to wife BBN? Qs what percentage can recover?why not ask about

St3 Cardio Mid sternotomy scar ,harvest graft ,no metallic ,systolic murmur at apex. Dx MR,PHT Invs,ttt Neurology examine cranial nerves Right Homonymous Hemianopia Causes?leasion beyond chiasma tract ,radiation,occipital lobe,pisterior cerebral artery occlusion,internal capsule. Causes?invs? St4 SAH on warfarin inr 4 with large onfarcts specialist see no benefit from surgery talk to wife BBN? Qs what percentage can recover?why not ask about organ donation?

BCC1 female bilateral arm pain My dd was muscular vs rheumatological vs vasculitis Postove finding pain with exertion absent pulse no systemic symptoms other criteria of takayasau absent First dd was takayasu What is your

dd?other vasculitis, GCA,PMR,FM One onvestigation to order?angiography

BCC2 hematemsis Positive data nsaids tds last week ,pmh of colitis and on pentasa and moderate alcohol no finding no organomegaly no persistent vomiting or liver cirrhosus ridk or hepatitis DD? PU vs Crohns VS MWS Others varices ,malignancy St1Abdomen Dark coloured patient with chevron scar no stigmata of cld no spleen with normal span liver, maxillary bossing ,no LNs, No ascites, DD? Thalassemia major, HHC ,aih,psc,infiltration. If this HHC what operation for this scar? Hepatecomy,transplant Chest Patient with rheumatoid hand COPD with bilateral basal crackles Dx?OLD with ILD Forget the rheumatoid what is other dx ? COPD invs? TTT?.

My exam experience in kolkata

st 4 pt non compliant to take steroid, kc Addison.
Husband pt of MS
St 5 (1)RA
LOC(2)
St (1)hepatosplenomegaly wth jaundice ILD wth systemic sclerosis
St 2)return traveller bloody diarrhoea grandfather ca colon dx at age 78, 2nd cousin having UC.
St 3 1)mixed mvd with af with hf, 2)spastic paraplegia traumatic.

My exam experience in kolkata

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St 2)return traveller bloody diarrhoea grandfather ca colon dx at age 78, 2nd cousin having UC .
St 3 1)mixed mvd with af with hf, 2)spastic paraplegia traumatic .
I just finished the exam b4 1 hour. Please pray for me

KOLKATA. St 1 liver transplant.
Chesy old with ILD in RA Sts changle bowel habbit
St3 hemonymous hemianopia examine cranial n Cardio biological valve with mr ,phtn
St5 bbn SAH with INR 4
St 5 takayasu Hemtatemsis nsaids vs crohns

So, I appeared for the third time in Kolkata. I took a course there, and I failed badly in the mock exam in the course. Got a very bad feedback and felt very disheartened. That was the last thing I needed before the exam. But my colleagues thought I was good enough, so that kept my lil flame alive .
The exam day was the most stressful. I couldn't sleep the whole night. Though I have tried to handle myself as a cool guy throughout my life, I felt like a fool that night. I asked for a taxi to drive me to the hospital and we got lost. There were four hospitals with the same name, and he didn't know neither did I. He called many

people over the phone and finally we reached there. So, I thanked him for allowing me to appear for the exam. He charged me double but I was in no mood to argue with this silly man .

So, finally my exam started. I was taken to neuro case which was stroke. Finished my examination before 1 min like in other stations. I was asked to examine the limbs. Surrogate was not only annoying but misinterpretating. Clearly the patient was in pain but surrogate said no. I caused pain to the patient. So, you can imagine what must have gone through my mind. Question and answers were easy, which I had practised hundred times and seen many such cases. So, easy diagnosis but I know they are not looking only at diagnosis. Felt sad but got 20/20 .

I was taken to cardio station where I was happy to see Midline sternotomy scar. So, I got the diagnosis and answered as MVR, but the examiner was asking me questions like what other treatment the patient is on beside anticoagulation. I didn't know. He also asked me causes of displaced apex beat, and I forgot to mention about heart failure or cardiomyopathy. So, got screwed. got 13/20, not badMy weakest skill is communication. Had tried a lot but strangely failed a lot. Confidence, I lack a lot. It was a
simple TB case where I had to assure her not to travel abroad becoz she had active TB. I missed many points like HIV, contact tracing, and so on. The examiner punched me with difficult MDR TB questions and I

almost fainted. Thank God, I survived. To my biggest surprise, I got 16/16 .

Station 5 was easy. Psoriatic arthropathy and stroke in young. These cases have already been mentioned in this site, so I don't want to talk about cases but my experience. For the first time during the exam, I felt good because I was able to diagnose both cases and answer properly to the examiners, hence I got 24 and 26. Pretty good .

As I mentioned previously I was quick with my examination, I finished before time in both respi and abdo, and gave some differentials for RA induced ILD, and hepatomegaly with funny scar(or scare, never seen such in my life). Did badly with the examiners in abdo, but got 20 and 19 respectively .

Finally, with little energy I was left with, I went to history station. Some people outside were laughing. That was probably the second time in my life when I hated people who were smiling because I found it hard to focus on the task at hand. Anyway, with fake smile and pseudo confidence I entered the room. But there was no surrogate. I had wait another two minutes. By this time my energy had drained and I think I looked like a Parkinson's patient with mask like facies. Took

history for 15 minutes regarding diarrhoea which I had practised for at least 20 times with my fren. So, it was easy but again with the examiners I was poor. Got 13/20 .

I thought I would fail after the exam. I told my family and frens that I might not make it again. When I saw 151/172, I was extremely happy and called everyone I knew .

My advice: Never ever give up. Keep on practising, and a time will come, as my fren told me - "You will pass even if you appear the exam in a drunk state ″.

Thank you all for taking time to read my experience .

God bless youKolkata April -2016

3rd cycle

Station 5 - MS - rt hemianopia with optic atrophy with h/o rt sided weakness

Station 5 - ? Ankylosing with ILD/COPD - wheezes as well as crepts - little odd

STation 1 - Chronic MR with ?? AR - you really had to strain for the AR murmur, no peripheral s/o AR - seem like a clear cut MR

Abdomen - hepatosplenomegaly - likely hemoglobinopathy

Station 2 - Wegner's /PAN/Autoimmune with Glomerulonephritis

Station 3 - Rheumatoid Lung - fixed hand deformities with effusion vs collapse

Neuro - Rt LR palsy with rotatory nystagmus - likely brain stem lesion ? vascular vs others

Station 4 - convincing patient regarding oral steroids for ulcerative colitis

Kuwait

1/24
******
Kuwait exam today diet1 5.3.24
Comm
Medical error
Comm 2
Htn ich pt on warfarin already but inr normal

Cvs AVR
Chest .. bronchiectasis
Abd ... ascties jaundice spleen
Neuro .. stroke

LCC ..
2ndry amenorhea due to 2ndry hemachromatosis

LCC 2 ...
Epistaxis hemoptoysis
Vasculitis / HHT

****
Jaber hospital Kuwait
3rd carrousel
Comm.
1-BBN adenocarcinoma with pleural effusion for investigation
2-STEMI underwent PCI refusing medication
LCC
1-Double vision and pain in the eye Graves eye disease
2-repeated chocking—systemic sclerosis
Clinical stations
CVS:AVR
Resp:COPD with fine tremors
Abd:renal transplant
Neuro:Parkinson’s
****

3/23
3rd carousel jaber hospital Kuwait

Station 3
(AVR metallic +MR)
neuro upper limb exam LMNL(ms disease)

Station 4 Medical error methotrexate +trimethoprim

Station 5
Uncontrolled DM + sensory peripheral neuropathy (complaint abnormal sensation of lower limb)

Second case difficult swallowing (in systemic sclerosis spot diagnosis) examiner want treatment for difficult swallowing

Station 2 intermittent headache for one month with history of stroke (6 month ago) with depression and anxiety

Station 1
renal transplant
lateral thoracotomy scar lobectomy.

Assalamo Alikom Dr Shaheen
My exam cases today

Station 1
Chest COPD
Abdomen Hepatomegaly

Station 2
History Postpartum hyperthyroidism

Station 3
Cardiac : VSD
Neuro : Cauda Equina

Station 4
Convincing husband about NGT insertion for his wife after losing capacity due to stroke

Station 5
Acromegaly
Fibromyalgia

LAHORE Cases compiled by Dr Hassan Mehmood

DIET 3/2023

Station 1 was ILD due to scleroderma and cirrhosis with ascites
Station 2 was back pain in elderly ? Malignant
Station 3 was MS with AF and cabg and cns case was stroke
Station 4 was confusing- young patient with MI and fatigue with betablockers for counselling, ethical issue was not clear
Station 5 was ankylosing spondylitis and carpal tunnel syndrome due to hypothyroidism

1. Resp = lung crepitation not changing with cough with joint deformity ILD with RA
Abd = mass in right upper abd hepatomegaly for differential
2. History = back pain with history of trauma, inflammatory type pain. Ankylosing spondylitis
3. BL lower limb UMN lesion with sensory loss upto umblicus —- could not do cerebellar or gait —- spinal cord lesion, demyelination tumour infection
4. On Methotrexate given trimethoprim for UTI —— bleeding 2 to pancytopenia

5a. SOB on exertion with 2 episode of syncope — exam systolic murmur increasing with expiration —- AS
5b. Joint pain, skin tightening mouth opening decreased no pul complication like fibrosis or pul hypertension —— systemic sclerosis
CVS station AF with MR for me as I got systolic murmur at apex but could not appreciate axillary radiation but others were saying diastolic murmur so MS

St 4
SAH want to DAMA , but she convinced at end for staying in hospital and for LP

St 5
Grittiness of and sitting standing issue eye ➡️ thyrotoxicosis
Swallowing problem ➡️SS

St 1
Fine crackles at at Bases ILD

Abdomen :: i said normal but some says hepatomegaly

Station 2
Compliants: vomiting / Nausea
Lymphoproliferative disorder post renal transplant sec to medications

Low WBC
Low plt
High ALT
Normal pancreatic level …
Complains vomiting / loose non bloody diarrhoea

Station 3
Peripheral neuropathy
Cardiac : to me it’s mitral stenosis

LCC - back pain with history of prostate ca
LCC - takayasu arteritis on steroids developed Cushing's

Communication
1 - latent TB one
2 - throat swab done samples lost. Counsel to do test again

Cardio - dextrocardia with AS
Neuro - spastic paraparesis with sensory level
Abdomen - cld with hepatomegaly
Lung - thoracotomy with Bronchiectasis

CVS AS
CNS LMN wit cerebellum
Resp pneumonectomu
Abdomen Jaundice

Long consultation …. Chest pain
second long consultation ….. malena

communication … epilepsy .. if safe in lamotrigine
Communication …. gangrene foot …. task was to convince him for amputation

DIET 1/2024

Lcc1
60 years old woman with htn 4-month hx of Shoulder pain & lower back pain with fever
Likely pmr, tender to touch

Lcc2 : 35 years with persistent fever and had a murmur seems IE

Communication 1
Seizure on suspected tumor on ct brain on temporal
Councel for mri.

Comm 2
Myotonia congenita consultation

Abd .just spleen
No other findings (?axillary Lymph node enlarged)

Chest : effusion

Cvs: MR with MS

Neuro : UL examination, fasciculations, LMN signs, all sensory modalities except joint proprioception lost

Cardio : severe Mr
Resp: copd with bronchiatasis
Neuro: bilateral spastic paraparesis
Abdomen: massive ascites

Comm1: young male with type 1 DM given wrong insulin and had 1 episode of hypoglycemia. Med error

counciling

Comm2: 27 male admitted with tiredness, diagnosed as type 2 dm and htn, started on metformin and ramipril. Concern y I don't have type 1 dm.

LCC1. 50 male with history of tiredness and fatigue. Hgb 10.8 not responding to iron tablets.
Exam: AS murmur

LCC2. 55 female with fatigue and tiredness and generlized bodyaches. On examination i think helitrope rash but not sure. I made it dermatomyosistis

Cvs AS with cabg
Chest cushinoid face with ronchi plus b/l basal crepts no jvp no pul htn...
Dds i gave
 copd with fibrosis
Bronchiectasis
Ild
Abd ... thin cachetic pale pt with stoma on left with hepatomegaly

Neuro .... parkinsons with right hemiparesis ..

Comm 1...
DNAR / ceiling of care . (End of life)

Comm2
Amiodrone induced fibrosis

Lcc1
Outside sob cough
Inside ... RA hands pt on mtx   h/o tb contact
Fine b/l crepts (around midaxillary line)
D/D RA with Ild
Mtx induced ild
Bronchiectasis

Lcc2
Outside pt presented eith mood probs and shakiness of hands
Inside pt wity chorea
Positive F/H ..
Viva on movement disorder
Types of hyperkinetic disorders

Cvs ..... AS
Chest .... ild vs bronchiectasis
Abdomen ....
hepatomegaly with ascites pigmentation
Neuro ...

Flaccid paraparesis with sensory loss

Comm1 ...
Father has ADPKD / speak to daugter
Comm 2 ...
Drug error missed antiepileptic dose/ concerns regarding driving

LCC 1 ...
Outside Joint pain with rash on leg
Inside h/o hep c dint take complete treatment . H/o raynauds given by pt
D/d for joint pain rash and raynauds asked in viva
Cryoglobinemia
CTD
Psoriasis

LCC2 ...
Outside ... prob with walking
Inside .... asymetic tremor rigidity
(Idiopathic parkinsons like features)
H/o anti pyschotics use

CVS.. MITRAL STENOSIS
CNS...CMTD
GIT...CLD WITH CLUBBING

RESP..LOBECTOMY WITH RHONCHI IN CHEST

LCC 1..
FATIGUE..
INSIDE HYPOTHROIDISM .. PT WAS TAKING AMIODARONE

LCC 2..
COUGH HEMOPTYSIS...
INSIDE BRONCHIECTASIS.. VS PULM TB VS LUNG CA

Communication 1.. pt on hemodialysis wants to quit on dialysis because of daily routine of dialysis

Communication 2... PD Admiited of Pneumonia..now drowsy missed dose of anti parkinson drugs in hospital Address daughter concern

Short cases
CVS : AS with CABG
Neuro : left cerebller syndrome
Resp : left sided pleural effusion
Gi : mass with ascites/ pkd??

Comm 1 : fire fighter having asthma . Asthma diagnosis , treatment , concerns(what about my job? Dont tell my wife)

Comm 2 : sle diagnosis & kidney biopsy(counsel the reluctant patient)

LCC 1 : ankle swelling outside . Inside uncontrolled diabetes & neuropathic ulcer with charcot joint

LCC 2 : c/o epigastric pain from 2 weeks . Gastric ulcer . Inside Acromegaly female spot diagnosis and on hx diagnosis was - MEN1

Cvs
Avr with ICD
Cns
Parkinson
Abdomen
Hepatosplenomegaly
Resp
Collapse with patent bronchi

Lcc
Systemic sclerosis
With ILD

Lcc 2
Thyroid eye disease

Cc
Palliative care

Breaking bad news

Lcc1...
60 yrs old lady with joint pain stiffness and back pain for 4 months.

LCC 2..
Young lady 34 yrs with joint pain and rash

Communication 1... Ibs explanation

Communication 2... Error tramadol +epsilpsy

CVS....
Don't know what was the case? mixed Aortic valve disease ??

Resp... Rt sided effusion

CNS... Upper limb wasting fasiculations with occipital area neck scar

Abd... Tense acisties + Spleen + Palmar erythema

06/08/2024
Lahore Morning carousel

Cvs: AS
Chest: effusion with consolidation
Neuro: unilateral lmn leg weakness
Abd: PCKD

Lcc 1: painless jaundice for ddx

Lcc 2: Sob

Comm1: counselling daughter about Cecal cancer

Comm 2: new diagnosis of UC in young lady

06/08/2024
Lahore Evening Carousel

Comm 1 : medical error missed dose of antibiotic

Lcc 1; bone pain and tiredness inside hypercalcemia features

Abd: ascites with hepatosplenomegaly

Comm 2: ACE inhibitor with non compliance

Resp; bronchiectasis

Lcc 2 : RA with acute flare

Cvs : AVR

Neuro: Myelopathy/ demyelinating disease

07/08/2024
Lahore Morning carousel

Lcc 1 : chronic diarrhea

Lcc 2 : dysphagia in systemic sclerosis

Cvs: diastolic murmur Ar with MS

Neuro: peripheral sensory neuropathy

Abd: CLD

Resp: Effusion

Comm 1 : Functional lupus
Comm 2 : Counselling for USG kub to rule out RAS for secondary hypertension

07/08/2024

Lahore Evening Carousa

Lcc 1 : abdominal distension and abdominal pain for 1 month
Budd chiari, mass lesion,ccf

Lcc 2 : constipation and abdominal pain hypothyroidism

Comm 1 ; insulin compliance

Comm 2 : Pneumatic dilatation scenario

Resp : COPD

Abd : jaundice with epigastric mass

Cardio: mixed valve lesion MS MR

Neuro ; Spastic paraparesis with absent reflexes and upgoing planters

Lahore Morning carousel
08/08/2024

LCC 1.. BACK PAIN 1 yr LOWER BACK ... ankylosing spondylitis (advance disease unable to move neck , shober only 1.5 cm)

LCC 2....COUGH FOR 8 month .
Inside history of Bronchiectasis . Previous pneumonia now phlem cough hemoptysis and SOB .
And also farmer

Communication
1. B streptococcal infection given benzyl penicillin develop steven johnson now shifting to icu and intubation .
2. Patient with previous diarrhoea was high risk for DVT , pt was not given . Now develop dvt .

Chest.....PLEURAL EFFUSION .

Cardio... C/ O PALPITATION . APEX BEAT WAS NOT clearly palpable . Pulse normal volume . MR / AS

Cns....Spastic paraparesis no sensory level .

Abd...psoriasis rash plus hepatomegaly 1_2 finger and massive spleenomegaly .
More interested about spleenomegaly .
Myeloproliferative.

Lahore Diet 2 *08/08/2024*
Evening Carousal

Cardio... MVR

Neuro...Cranial nerve examination ptosis bilateral
Case of MG

Comm 1: wrong insulin dose medical error

comm 2 : start of mtx for RA

Resp ; ILD

Abd: Jaundice with hepatosplenomegaly

Lcc 1 : Sob in a patient of RA

LCC 2 : pain Epigastrium burning pain non responding to ppi no red flags for DDx

09/08/2024
Lahore Morning Carousel

Cardio: MS

Neuro: Essential tremors vs.
Cerebellar tremors

Abd: PCKD

Chest: Bronchiectasis

LCC 1 : Obstructive jaundice for DDx

LCC 2: hand pain and arm pain unilateral for ddx vasculitis, PMR, CFS

Comm 1: wrong dose drug medical error

Comm 2 : recurrent pneumothorax for chest tube case

09/08/2024

Lahore Evening Carousal

Lcc : SOB and cough copd/ ILD/ HSP

Lcc : joint pain psoriatic arthropathy

Neuro : Differential weakness in lower limbs with mix features of umn and lmn

Cardio :MS

Chest : COPD with infective exacerbation/ COPD with ILD

Abd : hepatosplenomegaly ascites for psoriasis

Comm 1; Active TB wanting discharge

Comm 2 : MND for PEG

10/08/2024

Lahore Morning Carousel

Lcc: Single episode of collapse with palpitations with positive family History

Lcc : Polyarthritis RA

Neuro: cerebellar syndrome with peripheral neuropathy in upper limbs

Cardio : Dextrocardia with AS

Abd : Hepatosplenomegaly

Resp : Copd with infective exacerbation/ Bronchiectasis

Comm 1: IBS counselling starting amitryptaline

Comm 2 : Medical error wrong medication

10/08/2024

Lahore Evening Carousal

CVS....MR +AS

Neuro....asymetrical LMN monoparesis with sensory loss...plexopathy

Abdomen...hepatospleeno+ jaundice + ascites

Resp....unileteral pleural effusion...viva on tb

LCC...ch. diarrhea young female...no red flags.normal exam....IBS

LCC2...constpation in 60 yrs old male....
Hypothyroid.....inside..weight gain...fatigue. cold intolerance.....no featrures of hypercalcemia.....

Comm1...epilepsy...disease and management explanation

Comm 2....NSCLC Previously now parapalegia..MRI mets..
Explain the condition discuss managent options

Bangalore

St-1
CLD
ILD
ST-2
multiple collapse
St-3
Stroke
MR
St-4
Infective endocarditis, wanting DAMA
St-5
Recurrent abdominal pain with alchol,pain radiates to back

Weight gait,menstrual abnormality,HTN

******
1st carrousel, 23/6
Diet 2/23 Bangalore
D1 R1

S4 Failed Endoscopy in Dx Pharyngeal pouch
Explain condition and further Mx
S5
BCC1 Chest pain in SLE
BCC2 IR Mens Hypothy

S1
Resp Cough- ILD, Bronchiectasis? ,Consolidation
Abdomen : AVF

S2 SOB in Kn RA(recently Adalimumab)
Cgh S.t phlegm
DDx-Adalimumab induced Chest Inf,Card pb,. ...

S3
CVS MVR

CNS Rt sided Hemiplegic and Hemisensory loss(Lt CVA)

****
Bangalore 1st day 1st round
St 2. Consult 1. C/O- abdominal distension and leg swelling
T -37.7
Inside- patient can't communicate well. He said SOB and Tiredness but no swelling at tummy and legs
No bleeding
Hand shaking

Can't sleep well at night
Chronic alcoholic
PE- hepatomegaly but no ascites
No feature of heart failure
UO is normal
DDx of Generalized oedema
Including COL
Discuss about COL invx and treatment
St 3. CVS - No AF, No IE
Apex - not displaced
Murmur at mitral area, no radiation to axilla
Loud P2
I said MDM, but probably short systolic murmur at mitral area
CNS - RT sided hemiplegia without fascial palsy
St 4. Comm
Patient had severe interstitial lung disease and admitted with penumonia
Patient is not responding with the maximal treatment at HDU.
To talk with daughter for DNR and palliative care
Abdomen - Liver transplant
St 5. Consult 2. C/O - wt gain and fatigue
Scanty menstruations
No feature of hypothyroidism, cushion and acromegaly
PMH - PCOS
PE - fullness at the neck, hypertension and angle jerk is not sure for delayed relaxation
DDx - hypothyroidism
PCOS
Metabolic syndrome
Cushion
St 1. Comm - Amioderone induced lung fibrosis
Resp - crepts at the lung base and noisy breathing
DDx - interstitial lung disease
AE COPD
Bronchiectasis
HF
Discuss about COPD

*****
Cases
1. History
Palpitations
Sertraline, coffee intake, sudden death in family

Long qt
Hocm
Coffee intake

2. Communication
Newly diagnosed ulcerative colitis

3. Bcc
A) Malena , tiredness
Ra in nsaid, steroids

B)AS with recent onset breathlessness on adalimumab

4. Abd
Post liver transplant

Resp
Copd/ asthma

5. Cvs

Isolated MR

Neuro

Left sided LMN (wasting, pes cavus, hypotonia, decreased reflexes,) plus UMN (left extensor)
Told dds for mixed umn plus lmn

****

station:
1
respiratory :
rt sided trachea shifted & lower zone inspiratory crackles (most of the candidates didn't find it). Respi was a massacre to most of the candidates.

abdomen:
liver transplant with ascites (clear scar, no other organomegaly)

station 2:
subacute thyroiditis

station 3:
neuro:
* stroker
**? MS
lower motor type weakness e pin prick upto T10 but vibration intact, e cerebellar sign

cardio :
* MVR e AF
* midline sternotomy scar, no metallic click, no venous graft scar, no other murmur in heart.

station 4:

MTX + trimethoprim = medical error

station 5:
* TIA
* systemic sclerosis e pulmonary fibrosis

*****
Diet 2 2023
Bangalore
D1 R1
S4 Failed Endoscopy in Dx Pharyngeal pouch
Explain condition and further Mx

S5
BCC1: Chest pain in SLE
BCC2: IR Mens Hypothy

S1
Resp Cough- ILD, Bronchiectasis? ,Consolidation

Abdomen- AVF

S2 SOB in Kn RA(recently Adalimumab)
Cgh S.t phlegm
DDx-Adalimumab induced Chest Inf,Card pb,. ...

S3
CVS- MVR
CNS - Rt sided Hemiplegic and Hemisensory loss(Lt CVA)

******
Resp : ILD
Abdo: Renal transplant+ right hypochondrium scar, I told about liver transplant and resection of hepatic tumour/cyst, might be a case of ADPKD

Cardio : AF, everyone confused about whether MS or not
Neuro : Spastic paraplegia

St2 : young female+altered bowel habit + GP gave mebeverine but no improvement + Stress in life, no other positive history, gave dd of IBS/IBD

St 4: patient with stroke with hemiparesis, received 3 months physio, arm weakness improved, still can't mobilise, decision of discharge by MDT with full package of care. Explain a new functional baseline.

BCC1 : left sided weakness in a middle age male with a background of MS
BCC2 : young male with isolated vomiting of blood
****

Bangalore india,
Diet 2

Cases
1. History
Palpitations
Sertraline, coffee intake, sudden death in family

Long qt
HOCM
Coffee intake

2. Communication
Newly diagnosed ulcerative colitis

3. Bcc
A) Malena , tiredness
Ra in nsaid, steroids

B) AS with recent onset breathlessness on adalimumab

4. Abd
Post liver transplant

Resp
Copd/ asthma

5. Cvs

Isolated MR

Neuro

Left sided LMN (wasting, pes cavus, hypotonia, decreased reflexes,) plus UMN (left extensor)
Told dds for mixed UMN plus LMN

[23/06, 12:32 am] +971 55 369 4919: S1
f pt chest
rt lat thorac scar
+ scars for drain
exam
dec air entry
dec VR
examiner
Qs
Findings
DDx

investigation
if came With fever ?
said infection abscess

abdomen

barely detect splenomegaly
Qs
DDX
how much spleen ?

st
f pt
palpitation
recent delivery
PPT

st3

cvs

mr
midline sternotomy scar
no metallic click
obese
some said assoc AS

ddx
Mr
others said Hocm
not quite clear

neuro

LL
bilat spastic paraparesis
hyperreflexia
cerebellar lesion
ddx
inv

St4
UC
result of Bx from colo
go and sit with here
I forget name of pt when I discussed it with her
went good generally

st5
bcc1
chest pain
cardiac in nature

hx of hypothyroid and skin dz
I confabulate and invented PXE
Cvs exam NL

BCC 2
vitals showed
BP 95/62

hx of NAsopha CA
received Rtx

dx panhypopit
Bcc 1 dd what others gave?

cardiac
has neck goitre
on arbs ppi and thyroxine

rt armpit lesion
I cooked as PXE puckered skin or chicken appearance
discussed risk factors for IHD

Bangalore india diet 2

St 3.
MVR

Young lady with unilateral UMNL & LMNL in lower limbs with spastic left lower limb with pescavus and claw toes, and positive babinski sign, power reduced in UMNL pattern, sensation and wasting present, gait I couldnt appreciate, (they asked differentials for multiple sclerossi, stroke)

St 4: dementia of a pt with 92 yrs of age, talk to daughter, pt presented with chest infection, on admission she was found to have skin cancer, diagnosed as advanced skin cancer and dermatologist and the treating consultant decided, pt not a good candidate for surgery due to need for general anaesthesia also other treatment options were considered but then decided that they were not appropriate for her, and needed to talk about palliative care with daughter. Pt was stressing on any other treatment and second opinion, I told him that we can plan another meeting for second opinion as well, to discuss any treatment option other than palliative care with consultation.

St5.
Bcc1:
presentation: pt had swelling of abdomen, painless and history of taking too much alcohol, when I entered the room there was no swelling but pt was actually a follow up case.

CLD with hepatomegaly and leukonychia, midline laparotomy scar with ascitic drain scars,,

He was concerned if he has to continue the medication, also he told he had surgery for ulcers and hence had that midline laparotomy scar.

Bcc2: young male with malena and dizziness of one day origin, history of diclofenac intake since 2 weeks for knee injury which he had while playing football) o/e pt had epigastric tenderness also clubbing both in arms and legs and he was a smoker, examiner asked for causes of clubbing as well(but case was for lower gi bleed due to diclofenac)

St1: COPD /ILD. I was confused, I couldn't hear any crepitations (also there were diff opinions by other doctors-2 told copd n rest 2 ILd)

Right renal transplant with active av fistula, no scars for nephrectomy

St 2 polyuria with hypercalcemia, men2a.
In history she was a young female, with symptoms of hypercalcemia but no other supporting feature of men 2b, but family history was positive.

******_
St 3. MVR and
Young lady with unilateral umnl with lmnl in lowerlimbs with spastic left lower limb with pescavus and claw toes, and positive babinski sign, power reduced in umnl pattern, sensation and wasting present, gait I couldnt appreciate, (they asked differentials for multiple sclerossi, stroke)

St 4: dementia pt 92yrs of age, talk to daughter, pt presented with chest infection, on admission she was found to have skin cancer, diagnosed as advanced skin cancer and dermatologist and the trating consultant decided, pt not a good candidate for surgery due to need for general anaesthesia also other treatment options were considered but then decided that they were not appropriate for her, and needed to talk about palliative care with daughter. Pt was stressing on any other treatment and second opinion, I told for this we can plan another meeting for second opinion as well, to discuss any treatment option other than palliative care with consultation.

St5. Bcc1:Cld with hepatomegaly and leukonychia, midline laparotomy scar with ascitic drain scars, (presentation pt had swelling of abdomen, painless and history of taking too much alcohol, when I entered room there was no swelling but pt was an actually follow up case,

and was concered if he has to continue the medication, also he told he had surgery for ulcers and hence had that midline laparotomy scar)

Bcc2: young male with malena and dizziness of one day origin, history of diclofenac intake since 2weeks for knee injury which he had while playing foot ball) o/e pt had epigastric tenderness also clubbing both in arms and legs and he was a smoker, examiner asked for causes of clubbing as well(but case was for lower gi bleed due to diclofenac)
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Right renal transplant with active av fistula, no scars for nephrectomy
St 2 polyuria with hypercalcemia, men2a
On history she was a young female, with symptoms of hypercalcemia but no other supporting feature of men 2b, but family history was positive.

****
 Station 1
RS
Wheeze audible to unaided ear
Right lower lobe fine inspiratory crackles

Told ILD + obstructive airway disease

Abd
DCLD - jaundice shifting dullness hepatomegaly with dull traube's space dull
 ethanol

Station 2
Type 1 DM with neuropathy retinopathy nephropathy AF on apixaban and 4 antihypertensive
Multiple falls in 3 months

Station 3
CvS MR +/- MDM
CNS right hemiplegia told to examine only motor system upper and lower limbs
Not even allowed to examine the cranial nerves

 Station 4
AvR with IE
Advise to continue hospital stay

Station 5
Weight gain
Irregular periods
Difficulty to walk

Acute upper abdominal pain
With aggravation on food intake
Smoking and alcohol present

******
Station 2
TIA
Syncope
Hypoglycemia
Diabetic autonomic neuropathy
Drug induced

Station 5
First case - cushing disease
metabolic syndrome

Second case
Pancreatitis
Peptic ulcer disease / Gastritis

****
St 3. MVR and

Young lady with unilateral umnl with lmnl in lowerlimbs with spastic left lower limb with pescavus and claw toes, and positive babinski sign, power reduced in umnl pattern, sensation and wasting present, gait I couldnt appreciate, (they asked differentials for multiple sclerosis , stroke)

St 4: dementia pt 92yrs of age, talk to daughter, pt presented with chest infection, on admission she was found to have skin cancer, diagnosed as advanced skin cancer and dermatologist and the trating consultant decided, pt not a good candidate for surgery due to need for general anaesthesia also other treatment options were considered but then decided that they were not appropriate for her, and needed to talk about palliative care with daughter. Pt was stressing on any other treatment and second opinion, I told for this we can plan another meeting for second opinion as well, to discuss any treatment option other than palliative care with consultation.

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CLD with hepatomegaly and leukonychia, midline laparotomy scar with ascitic drain scars.

He told he had surgery for ulcers and hence had that midline laparotomy scar

and was concerned if he had to continue the medication.

Bcc2: young male with **malena** and **dizziness** of one day origin.,

History of diclofenac intake since 2 weeks for knee injury which he had while playing football) o/e pt had epigastric tenderness also clubbing both in arms and legs and he was a smoker, examiner asked for causes of clubbing as well.

(but case was for lower GI bleed due to diclofenac)

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Right renal transplant with active av fistula, no scars for nephrectomy

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On history she was a young female, with symptoms of hypercalcemia but no other supporting feature of men 2b, but family history was positive.

***
Diet 2 Bengalore
D1 R1
S4 Failed Endoscopy in Dx Pharyngeal pouch
    Explain condition and further Mx
S5
BCC1 Chest pain in SLE
BCC2 IR Mens Hypothy

S1
Resp Cough-ILD Br'ectasis? ,Consolidation
Abd AVF

S2 SOB in Kn RA(recently Adalimumab)
    Cgh S.t phlegm
  DDx-Adalimumab induced Chest Inf,Card pb,. ...

S3
CVS MVR
CNS Rt sided Hemiplegic and Hemisen loss(Lt CVA)

S4 Concerns-Is my dysphagiadue to CA? Further Ix,Mx. (F/H CA in Dad,Bro)
S2 Concerns-Heart Attack? Is because of drug(it control my jt pain well),Should I stop? Should I be admitted?
———————- ————————————————————————————————-
Banglore india,
Diet 2 Third round

Cases
1. History
Palpitations
Sertraline, coffee intake, sudden death in family

Long qt
Hocm

Coffee intake

2. Communication
Newly diagnosed ulcerative colitis

3. Bcc
A) Malena , tiredness
Ra in nsaid, steroids

B)AS with recent onset breathlessness on adalimumab

4. Abd
Post liver transplant

Resp
Copd/ asthma

5. Cvs

Isolated MR

Neuro

Left sided LMN (wasting, pes cavus, hypotonia, decreased reflexes,) plus UMN (left extensor)
Told dds for mixed umn plus lmn
_____-
Diet 2 Day 2 Second round

History - DM type 1 repeated Hypo attack
Comm - AVR get IE, want to go home

BCC - wt gain, irregular mass - Cushing
BCC - acute epigastric pain - Pancreatitis

Resp - COPD? Crepts in both lower and middle zone?
Abd - COL with PHT

CVS - MS/MR (not sure)
Neuro - Hemiplegia
_____-

Banglore india diet 2

St 3. MVR and
Young lady with unilateral umnl with lmnl in lowerlimbs with spastic left lower limb with pescavus and claw toes, and positive babinski sign, power reduced in umnl pattern,

sensation and wasting present, gait I couldnt appreciate, (they asked differentials for multiple sclerossi, stroke)
St 4: dementia pt 92yrs of age, talk to daughter, pt presented with chest infection, on admission she was found to have skin cancer, diagnosed as advanced skin cancer and dermatologist and the trating consultant decided, pt not a good candidate for surgery due to need for general anaesthesia also other treatment options were considered but then decided that they were not appropriate for her, and needed to talk about palliative care with daughter. Pt was stressing on any other treatment and second opinion, I told for this we can plan another meeting for second opinion as well, to discuss any treatment option other than palliative care with consultation.
St5. Bcc1:Cld with hepatomegaly and leukonykia, midline laparotomy scar with ascitic drain scars, (presetnation pt had swelling of abdomen, painless and history of taking too much alcohol, when I entered room there was no swelling but pt was an actually follow up case, and was concered if he has to continue the medication, also he told he had surgery for ulcers and hence had that midline laparotomy scar)
Bcc2: young male with malena and dizziness of one day origin, history of diclofenac intake since 2weeks for knee injury which he had while playing foot ball) o/e pt had epigastric tenderness also clubbing both in arms and legs and he was a smoker, examiner asked for causes of clubbing as well(but case was for lower gi bleed due to diclofenac)
St1: copd /ild im confused, I couldnt hear any crepitations (also there were diff opinions by other doctors-2 told copd n rest 2 ILd)

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St 2 polyuria with hypercalcemia, men2a
On history she was a young female, with symptoms of hypercalcemia but no other supporting feature of men 2b, but family history was postive.

S1
f pt chest
rt lat thorac scar
+ scars for drain
exam
dec air entry
dec VR
examiner
Qs
Findings
DDx
investigation
if came W fever ?
said infection abscesd

abdomen

barely detect splenomegaly
Qs
DDX

how much spleen ?

st
f pt
palpitation
recent delivery
PPT

st3

cvs

mr
midline sternotomy scar
no metalick click
obese
some said assoc As
ddx
Mr
others said Hocm
not quite clear

neuro

LL
bilat spastic paraparesis
hyperreflexia
cerebellar lesion
ddx
inv

St4
UC
result of Bx from colo
go and sit with here
I forget name of pt when I discussed it with her
went good generally

st5
bcc1
chest pain
cardiac in nature

hx of hypothyroid and skin dz
I confabulate and invented PXE
Cvs exam NL

BCC 2

vitals showed
BP 95/62

hx of NAsopha CA
received Rtx

dx panhypopit
_____

Bangalore Diet 2 Day 3
Last day, last round
1 - COPD, AVF with anaemia
2 - Dizziness with palpitation
3 - Hemiplegia, MR or MS not sure
4 - gliclazide overdose self discharge
BCC 1 - LIF pain with fever with bloody stool
BCC 2 - abd distension with acute confusion - CLD patient
_____-
Day 3 2nd round
ST2 - 40 year female, Back pain in pt with OP # at T10,
(Inside LM+ off and on, no steatorrhoea, no blood, LOW+, LOA+,
FH of ca breast in mother+, K/C/O asthma on blue and brown inhaler)
? OP, OM, with Coeliac disease, To exclude malignancy
ST4 - IB$ with aminophylline
Respiration - COPD
Abdomen - CLI + Hepatomegaly, clubbing + leconychia+
CVS - MVP, PsM at apex, no radiation and apex not displaced
Neuro - Hemiplegia
BCC 1 - LM and abdominal pain after having pizza, radiate to back - ? Pancreatitis, Cholecysitis ? , FH of GS+
RHC tenderness +, ? Medical cause of abdo pain
BCC 2 - Young girl with collapse and palpitation , Sp02 93%, FH of sudden death +, DDx - PE, HOCM, Long QT
_____-

******
#St_5_Collections
BANGALORE BCC

1.copd with sudden breathing difficulty and rt sided chest pain..
o/e Dec breath sound.rt mid.
dd was ptx,pul embolism ,pneumonia. It was good

2.female was increase weight,,increase bp,,,and
proximal myopathy, ,o e no thyroid
abnormalities, ,some rash,,and proximal
myopathy,,features of osteoarthritis, ,knee jt,leg

oedema, ,
dd,was cushing, ,hypothyroidism, metabolic syndrome, ,discuss was on cushing. .
Dx—-> hypothyroidism
H/O… cold intolerance, constipation, infertility
O/E… Normal (Surrogate)

3.1st case 30 yrs old lady with high prolactin levels and normal TSH c/o scanty and irregular menstruation.

outside 38 yr female with irregular menses, pain in thighs, and wt gain, high BP, oxygen saturation 92%...inside obese pt with pitting oedema + bibasal crepts , proximal myopathy, wt gain, OSAS , diagnosed as PCOS.....concerns ;: is it bcz of hormonal problems?
Crossing: ddx: PCOS with cushing, hypothyroidism, metabolic syndrome, with OSAS, ix and Mx of each...got 27/28
weight gain
Patient is surrogate . No abnormal finding on o/e
History- generalized weight gain with normal appetite, irregular menstruation and nad

4. 26 yrs old lady with SLE since 6 yrs presented with right sided pleuritic chest pain ,with fever. Discussion about DD of chest pain.
outside 28 yr female with chest pain radiating to lft arm.....inside typical History of ACS, diagnosed as SLE (pt do not want to say....said after lots of hammering) taking prednisolone and hydroxychloroquine for SLE...concern: is it serious?
Crossing: ddx...ACS, GERD, PE, esophageal spasm.
Ix and Mx of ACS, risk factors of DVT...what if troponins are raised?
Cause of ACS?...got 26/28
SLE with chest pain
Not real patient
No signs at all
At that day I got fever and can't concentrate.
I examined only at chair
Actually Pt is sitting in front of examiner . I examined over the clothes .
18/28

chest pain
History- left sided sharp chest pain,1 hour duration, radiation (dont remember) underlying SLE
They want AC$ as first then ddx Middle age lady
Wt gain and feeling low
Apart from that no signs
Not real patient
She also sitting in front of examiner.
I examined at there also😔
23/28

5. known hypothyroid taking medications come with fatigue
hypothyroid symptoms again
Dx: ? Recurrence of hypothyroid due to drug noncompliance

6. fatigue for 1yr
RTA history present and CT head normal
Seen psychiatrist and take medications but not relieve
Family history of fatigue also present
Dx: chronic fatigue syndrome.

7. epigastric pain, epigastric lump, wt loss, ascites
Pt was very sick. Her sister gave History.

8.
ank spond patient on biologics got fever and cough for 2 weeks.
Clinically no signs of ank spond or pneumonia.

9. chronic headache ? Due to sinusitis. No red flag sign

10.Know hypothyroid for 3 years with progressive headache.

11. young female with palpitation. Her father had palpitation and heart attack.
Pt is normal. Sinus tachycardia only.
Concern.. ht attack?
Dx.. SVT???

12. known COPD pt comes to you with

palpitation. Taking an inhaler.
Concern.. heart attack?
Dx... palpitation due to inhaler SE

13. 60 yrs old gentleman comes with multiple joint pain and back pain. He had previous history of psoriasis.
Dx… psoriatic arthropathy. Normal surrogate.

14. 50yrs old man come with progressive SOB and dry cough.
RA history present and taking methotrexate
Chronic smoker.
Normal surrogate. No signs.
Gave Ddx.

15. Hyperthyroid
16. Loss of memory

Ddx for dementia.

****
Bangalore ,,, 2018
Station 2 : was recurring hypoglycemia in type 1 dm with weight loss anaemia , preproliferative retinopathy , Nephro pathy, and bloating of abd
Station 4 : SAH refusing LP and wanting self discharge
BCC 1 : joint pain in a patient with diagnosed psoriasis... he had back pain n dip joint... very strange surrogate . Talking in muffled voice. Examination finding very very normal
BCC 2 : was sob n dry cough in a ra patient on methotrexate n whos work exposes him to asbestos and is a smoker
Resp : COPD
Abdomen > Ckd with ascitis with fistula... some candidate found hepatomegally . Was asking dd of hepatomegally in ckd pt
Cardio : Mvr with pht with af with heart failure
Neuro : Hemiplegia

****
My experience of Passing Paces from Banglore, India, 5th august....
Started with St1 :
Respi : man with resting dyspnoea, prominent resp. accesory muscles, barrel shsped chest, I/v cannula, bedside oxygen nasal cannula, palmar

erythema, peripheral cysnosis, bounding pulse.
Resp examination consistent with COPD.
Dx: acute infective exaxerbation of copd.
crossing : dx, ix, mx, what wud i do if this man came to casualty with breathlessness.....got 20/20
Abdomen : a very obese ,middle aged man with HUGE ascites, gross generalised pigmentation, i/v cannula, scar in RIF consistent with ascitic tap, peripheral odema, deep jaundice and umblical hernia.
Dx : decompensated CLD with portal htn.
Crossing : any organomegaly? I said i could not appreciate due to huge ascites.
Single cause of cld in this sp.pt? I wanted to say chr viral hepatitis but i decided to be practical so i said, as becz pt is having elevated BMI so most likely NASH or ALD.
Why pherp odema nd basal creps? Said maybe volume overload due to persistent aldosterone activation due to underfilling of circulation or due to concomitant CKD as pt is slso hyperpigmrnted.
Ix And Mx. Got 20/20
St2: a 28 yr old man with dudden onset rt knee swelling and lft ankle swelling.
Pt gives vague history...describes pain to be mechanical...on further query admitted an episode of food poisoning, brother with psoriasis..rest sll history negative. There was no dysuria nd pt is umnarried....so here made the mistake of not taking sexual history as i thot no need of it....also did not take drug allergy history.
crossing : ddx: psoriatic arthritis, reactive arthritis,enteropathic..
What things u ruled out? Said,male SLE, gout, pseudogout, septic arthritis, sarcoidosis
What are assos systemuc disease? Said , sarcoidosis...examiner pinpointed me that i missed serum sickness arthritis as dint take allergy history nd also sexual history....then asked abt ix , mx, how to rule out gout nd poseudogout. Got 12/20
St3.....cardio:
Young man seemed to be drowsy, pulse normal, apex beat in the 4rth ICS (made me confused) signs of Pulm HTN present, with PSM with

radiation to axilla
Crossing: dx: severe MR with PHTN.
Then examiner asked me to show where i got Rt parasternal heave (i got scared) and thrn he checked himself.
What might be other assos lesion? I said possible MS ..need to find out by echo
Ddx: VSD , MVP
Y not VSD: said rad to axilla
Ix....details about each nd every Ix findings....got 20/20
Neuro: young man with compaints of dropping things from hand..exsmine UL
Rt hand flexed with fingers flexed in typical stoke pisition....ex consistent with pyramidal pattern of wasting nd weakness snd UMNL in rt with loss of all modalities of sensation except joint position...left limb normal.
Crossing : dx: left sided stroke eith rt hrmiparesis
Ddx: all of a sudden i blacked out nd ssid nothing.
Details of Ix and Mx.
Long term mx ? Said cvs risk factor mx and phisiothersphy...got 19/20
St4: 84 yr lady with fall csme to casualty..test revealed UTI...later pt is confused...started approp antibiitic..pt now improved also there is some resting tremor..so diagonosed as idio parkinsons nd given careldopa..she was having mild tremor since 3 yrs but never attented medical advice...only daughter came from abroad to discuss.
Many issues: pt is only carer of husbsnd who is having stroke., pt is living alone, one son but reluctant to look after, pt's hobby is painting...so pt is sad she cant paint due to tremor...y confusion? Is this true that slowly she will start to forget things? Why she was not started on parkinson Rx earlier? How can she take care of her mother? Any Rx avsilable ?
Crossing: what issues did i come across?
Why not started Rx earlier?is there any harm to pt for not starting Rx earlier?
Details abt ix and mx with mode of action and side effects of each drug, surgical Rx? Got 16/16
St5 ...a) outside 38 yr female eith irregular menses, pain in thighs, nd wt gain, high BP,

oxygrn saturation 92%...inside obese pt with pitting odrma + bibasal creps , proximal myopathy, wt gain, OSAS , diagonosed as PCOS.....concerns ;: is it bcz of hormonal problems?
Crossing: ddx: PCOS with cushing, hypothyroidism, metabolic syndrome, with OSAS, ix and Mx of each...got 27/28
B) outside 28 yr female with chedt pain radiating to lft arm.....inside typicsl History of ACS, diagonosed as SLE (pt do not want to say....said after lots of hammering) taking prednisolone snd hydroxychlorowuine for SLE...concern: is it serious?
Crossing: ddx...ACS, GERD, PE, esophageal spasm.
Ix nd Mx of ACS, risk factors of DVT...ehat if troponins are raised?
Cause of ACS?...got 26/28

ALHAMDULILLAH passed with a total score of 160..

*****

India(Bengaluru)
Station 4 , 26yrs old lady physiotherapy as st. Working in stroke unit .admitted with flaccid limb weakness , CT and MRI normal explain about functional weakness . Pt was reluctant to accept the diagnosis and wish to see neurologist urgently don't want to see psychiatrist .social issue about job , and grandmother died 3 months back with stroke.discussed about psychiatric referral and physiotherapy . Station 5 - 1 st case 30 yrs old lady with high prolactin levels and normal TSH c/o scanty and irregular menstruation. 2nd case- 26 yrs old lady with SLE since 6 yrs presented with right sided pleuritic chest pain ,with fever. Discussion about DD of chest pain. Station 1 -- Respiratory -- lung fibrosis Abdomen = ascites with chronic liver disease , jaundice, parotid swelling,flapping tremor, spider nevi , examiner asked about if there is fever what can be the cause and how to treat .management of ascites . Station 2 - 30 yrs old lady with facial and neck swelling sudden onset ,adopted child , no other positive history , concern about allergy .DDhereditary angioedema . Investigation and treatment .
Station 3 Neuro - right sided weakness , with

proximal wasting hypertonia, hyperreflexia ,dyddiadokokinesia ,sensory normal . Cardio -- young lady with MS - tapping apex sinus rhythm ,loud S1 diastolic murmur , phtn and raised jvp .
bangalore. Manipal ..7/4/17
Started with st2...Anaemia (MHA.) H/o ibs 6 yrs on peppermint oil,occasion leg swelling,ho rta and nsaids ,father died of cancer colon,mother taking inj.3 monthly for anaemia,so many issues, ,DD was so many issues..coeliac..nsaids, ,ulcer
St3,cardio MS,,neuro..patient was very un cooperative, not following me,,actually language barrier was prob. I didn't understand what he told about sensation, ,planter was very confusing, ,Indian examiner didn't tell anything! !
St.4 esrd bbn and plan of mx
St5,,copd with sudden breathing difficulty and rt sided chest pain.. o/e Dec breath sound.rt mid.dd was ptx,pul embolism, ,pneumonia. It was good
St5 female was increase weight,,increase bp,,,and proximal myopathy, ,o e no thyroid abnormalities, ,some rash,,and proximal myopathy,,features of osteoarthritis, ,knee jt,leg oedema, ,dd,was cushing, ,hypothyroidism, metabolic syndrome, ,discuss was on cushing. .

*****

Bangalore India 2017/1
Cvs
Very loud MR with displaced apex and thrill.
Otherwise not in failure. But also noted ar and tr.
Collapsing pulse
Asked about how to ascertain cause of mr- echo and angiography
Respi
Left pleural effusion
Asked about lights criteria
History
Young woman overtly hypothyroid post partum. No other features of hypopituitarism. History of pph with massive transfusion. Still able to breastfeed. Ddx Sheehan , postpartum thyroiditis

Neuro
Old CVA with left hemiparesis, left umn facial nerve palsy
Asked about mx for acute and chronic stroke ie rehab
Abdo

Cld, cachexia with ascites
Asked about peritoneal tap
Communication
Elderly lady with obstructive jaundice suspecting ca. All investigations negative. To convey the uncertainty. BBN. Advise next step. Concern is what if daughter wants to keep the news from mother.

Bcc1 ank spon patient on biologics got fever and cough. Clinically no signs of ank spon or pneumonia.

Bcc 2 chronic headache ? Due to sinusitis. No red flag sign
****
Bangalore. Manipal ..7/4/17
st2...Anaemia (MHA.) H/o ibs 6 yrs on peppermint oil,occasion leg swelling,ho rta and nsaids ,father died of cancer colon,mother taking inj.3 monthly for anaemia,so many issues, ,DD was so many issues..coeliac..nsaids, ,ulcer
St3,cardio MS,,neuro..patient was very un cooperative, not following me,,actually language barrier was prob. I didn't understand what he told about sensation, ,planter was very confusing, ,Indian examiner didn't tell anything!
!
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Chennai

1/24
****
Sundaram medical foundation chennai
22.03.24 (3rd carousal)

LCC: IBD acute flare by Restaurant meal during travel.
DD : Infective diaarhoea (ask about tx of infective diarrhoea)

Now pt has bloody diarrhoa following travel. Bt pt's wife has watery diarrhoea which is resolved.

PHO bloody stool 2 yrs ago. Has backpain, GP said Machanical pain,

★LCC-2: Metabolic syndrome, Alcoholic liver disease.

Scenario information: abnormal LFT, HTN,DM, OBese, High blood lipid, USG: multiple 3 cm hypoechoic mass.

Exam: dummy pt, only has AN in neck.

Ask about SOL : what might be the reason... They Wanted to listen CT abdomen anf AFP to exclude liver mass.
Mx: stop alcohol, wt reduction, optimise pre-existing metformin

communication-1: very big scenario about Adenoca of liver with unknown primary, pt was lucid. Task about no active tx

Task: Talk to pt's daughter to
 convince her to respect his father's wish, mx, concern, ans of Q..

(Daughter was rigid, she doesn't want to inform this bad news to her father) and many other concern.

★Comm-2: poor controlled astham. Pt was reluctant to take steroid tablet as she already had voice change problem, fear of wt gain. On further exploration she said she didn't gurgle >> Have to advice regarding proper techni and post use gurgling.

★Cardio: DVR, Mid sternotomy + basal creps, SOB, LP HEAVE, Palpable P2 was present

★Neuro:LSH With facial weakness....

★Respi: COPD With Rt apical fibrosis. Theachea is in central (some says To Rt)
Ask about why Rt sided percussion note dull, breathsound present but reduced..

Ask Q about COPD Mx and LTOT.

★Abdomen: ESRD due to PKD (Palpable) With 3 fistula, 1 is functioning with recent needle mark, other 2 was inactive, ascites?

Asked about ascites but the percussion note was resonant in the whole abdomen.

Asked about the cause of bilateral enlarged kidney cause.
Ask Mx.
just the bell rang....

******
Yesterday's session at SMF, Chennai

[03-23, 7:20 a.m.] Jonathan: Communication:
1. Physiotherapist joined 3 months in stroke unit. Had weakness of right upper and limb weakness. CT and MRI Brain normal. Staff nurse told that she is faking . She is upset and want to talk to neurology register.
Task - Explain the diagnosis and discuss MRI report.
2. 27 yr lady with seizure disorder and last seizure 10 yr back. Admitted for arthroscopic 1 week back. Started on Tramadol and paracetamol. Now admitted with seizure. Pharmacist told tramadol shud not be given.
Should inform DVLA about seizure and DVLA will take its own time to find out that her proved seizure due to medicine and will take time for investigation .
Patient is furious and want to discuss about why medicine was given and her concern about driving
[03-23, 7:20 a.m.] Jonathan: CC - INTERMITTENT FEVER 1 MONTH AND TREATED FOR CHEST INFECTION 5 DAYS BACK.
CC- PATIENT HAD COLLAPSE ONE EPISODE occcsional. In last 8 MONTHS had 3 episodes of LOC . BLOOD INVESTIGATING SHOW raised MCV but Vit B12 and folate normal.

******
Chennai 22.3.24 2nd carousel

communication
1 .Patient known case of seizure on levitracetam for 10 yrs ,pt had arthroplasty 1 week back given tramadol,now presented with 1 episode of seizure..medical error

2.functional weakness of limbs

consultation

1.fever intermittent for 1 month ,cough with greenish expectoration ,night sweats
2.young male 3 episode of collapse with jerking
clinicals
1.abd-adpkd with functioning avfistula
2.Rs-broncheicatasis with clubbing
3.cns-left hemiplegia with facial palsy

4.cvs -midline sternotomy scar present woth systolic murmur
Avr i think mam
*****
chennai 21.03.2024 *FIRST SESSION*

Communication -
1. Disclose elderly patient dying to daughter, DNR signed by elderly patient 2 months back

2. Talk to husband of wife metastatic lung ca with brain and bone mets admitted with seizures and recovering planned for discharge, pain medication (fentanyl patch) was missed and not given during hospital stay, patient in pain, acknowledge medical error and apologise

CC
1. Young male with diarrhoea with blood and mucus for two months (dd - ibd, tb ileocecal, amebiasis)

2. Young male with night sweats and weight loss for four weeks (tb, malaria, lymphoma, hiv etc)

RS - findings suggestive of bilateral volume loss (right>left) and trachea shift to right but patient had clubbing
DD fibrosis, ild, bronchiectasis

CVS - post avr

Abdomen - post renal transplant ckd with functioning av fistula now with ascites and jaundice

CNS - 60 year old female with walking difficulty: asymmetric paraparesis (right > left) with sensory loss (jps, pain fine touch all lost) on right lower limb with cerebellar signs (impaired heel shin test)

examiner did not allow for upper limb or gait examination.

[**********

Chennai PM - 21/3/24

Comm1: pheochromocytoma - delayed diagnosis and concerns with symptoms; how to deal with complaints

Comm2: Inform risks and complications if T1DM not fully treated

Resp: L-apical fibrosis (L-apical sunken, posterior asymmetry - possibly post-TB)

Cardio: AVR (median sternotomy scar on a hairy chest with AVR click and flow systolic murmur), no signs of IE and heart failure

Neuro: L-LL polio (LMN signs with pes cavus and lower back scars - talk about polio vaccinations and treatment)

Abdo: Ascites, R-IF scar (no ballotable mass), functioning R-UL AVF and jaundice, fluid overload

Consult1: young man with haematuria and R-loin pain, HTN and enlarged R-kidney

(APKD - ask about APKD types, which chromosome affected, talk about complications esp. Hypertension)

Consult2: young man with bloody diarrhoea (overlaying lying infection with recent travel and possible flare up of underlying IBD, enteric arthropathy (no active ankylosing signs), % of bowel cancer in his case , talk about different stool infections and Abx to use.

****
Chennai / india 18.3.24
Rs I think fibrocavitary
Abd ckd
CVS AVR
Cns subacute combined degeneration of cord I think. I answered peripheral neuropathy and gave dad
Consultation one right loin pain and hypertension with postural hypotension
Comm1
Sle for kidney biopsy
Comm2
Parkinson’s patient drug not given in hospital stay

*****
chennai 19.3.24

comm 1: BBN of mri with contrast
Comm 2 : BBN and genetic counselling for myotonic dystrophy

lcc 1 :Diabetic autonomic neuropathy
Lcc 2 : Thyromegaly in ESRD pt

Respi : B/l bronchiectasis
Abd : CLD with Esrd on MHD

Neuro : Spastic Paraparesis without sensory
cardio : PS with TR with Pul HtN

******
Chennai 19.3.24

Consultation 1 palpitations one episode thyroid versus parasosymal AF

Consultation 2
diabetic peripheral neuropathy

Comm 1
Methotrexate induced fibrosis..explanation of conditions, return to work__

Communication 2
 _ Hodgkins lymphoma explanation and further management

Resp - Right pleural effusion/ pleural thickening/ carcinoma with functioning AV fistula,
Cvs_ systolic murmur
Cns_ left hemiplegia
Abdomen_ ADPKD
*****
SMF diet 1 … 22/3/2024

Communication:
1. Physiotherapist joined 3 months in stroke unit. Had weakness of right upper and limb weakness. CT and MRI Brain normal. Staff nurse told that she is faking . She is upset and want to talk to neurology register.
Task - Explain the diagnosis and discuss MRI report.

2. 27 yr lady with seizure disorder and last seizure 10 yr back. Admitted for arthroscopic 1 week back. Started on Tramadol and paracetamol. Now admitted with seizure. Pharmacist told tramadol shud not be given.
Should inform DVLA about seizure and DVLA will take its own time to find out that her proved seizure due to medicine and will take time for investigation .
Patient is furious and want to discuss about why medicine was given and her concern about driving

LCC 1
- INTERMITTENT FEVER 1 MONTH AND TREATED FOR CHEST INFECTION 5 DAYS BACK.
-
LCC 2:
PATIENT HAD COLLAPSE ONE EPISODE occasional. In last 8 MONTHS had 3 episodes of LOC . BLOOD INVESTIGATION SHOW raised MCV but Vit B12 and folate normal.

SHORT CASES :

CVS - AR
RS - B/l bronchiectasis
Cns - left hemiplegia
Abd - ADPKD

****
3/23
DIET 3 🎯✍️
?? Centre:

St1 a
Middle age male with pneumococcal meningitis very severe condition came in ward and admitted in icu , in icu he was intubated and ventilated and now wean off from ventilation and breathing spontaneously by trechostomy ,and NG in place ,patient is awake but still confused and there is rt sided weakness as wel but prognosis is poor.
Task discuss with wife about poor prognosis and uncertainty

Communication 2

Young lady was diagnosed with hyperthyroidism 1 year back and was started on Carbimazole and propranolol, his tsh came to normal and dose was adjusted, she lost followup for almost 3 months and stopped carbimazole,another dr told her about radioactive iodine therapy but consultant thinks that it's not best option for her as she is in reproductive age

Task counsel her to take carbomazole and address any concern if she has.

Lcc1: 28 years old heamaturia
with bp 150/90mmhg
Urine. RBC cast 3 to 4
Proteinuria 1 +
Leucocyte 3

Painless heamaturia/,no anybleeding from any where no flu like illness
Same episode 1 year back
Ddx apkd
GN iga
Stone

Fx. Sister died of bleed in brain and father has htn

Lcc2
.. age lady having hx of fall
Inside bl knee pain and mechanical pain
OA
Along with hx of noisy breathing for 1 year
Chest has bl ronchi

DHx : tramadol and paracetamol,no hx of steroids

Neuro
Check cranial nerve
Facial n palsy

Cardio:
A fib
Diffuse wheeze and fine basal crepts
Ms s1 loud

Abdomen: ADPKD RRT

Chest apical fibrosis

****
🎯🎯✍️

Chennai Sundaram diet3

Communication 1: 102 year old grandmother, hemorrhagic CVA . About to die. Explain end of life care to granddaughter

Abdomen: ADPKD in failure. Multiple left AV fistula. Recent needling. One was removed.

No other peripheral signs.

Cc1: middle aged man with **fever and weight loss** for 1 month.

Submandibular lymphadenopathy, mild hepatomegaly??

D/D : TB, malignant, abscess.

Communication: wrong second HIV test. Explain and apologise.

CC2: Multinodular goitre. Diffusely enlarged thyroid. Euthyroid patient. Asked abt investigations. How to rule out cancer.

CVS: midline sternotomy with no murmur or clicks. RV heave.

?VSD/ASD. ? Biological valve

Neuro: Lower limbs. Asymmetrical LMN weakness.
? MND ? Polio.

Respiratory : tar staining.

Chest: bilateral scattered wheezes. I couldn't appreciate crepts. Others did. COPD/ Asthma.

Some say it was post- TB fibrosis.
Lost.

*Collected

****
Chennai diet 3 on October 16, 2023 afternoon (3pm) Carousel Started with

LCC 1: 65 yr old man presents with hand and leg pain, BP 150/70, Pulse 80, Spo2 98%.

On further questioning, pain and swelling on both hands for about 2 yrs, pain burning in nature, comes and goes, morning stiffness last for 1 hr. GP prescribed paracetamol. He also has pain in feet, no numbness or pin needle sensation. Also has pain & swelling in his left knee for a few weeks, h/o HTN, DM. He Takes amlodipine, Metformin, herbal medicine.

I said Dx: RA, DD: RA, OA, PN on hands & Crystal arthropathy on knee.

Asked what labs I would do? : CBC, inflammatory markers, RF, Anti-ccp, serum uric acid, UnE, FBS, HbA1C, Lipid profile, Xray followed by joint aspiration, if needed.

Rx details of RA: all

In that case while the surrogate misdirected me, the examiner works as surrogate. He was very nice.

Cardio: Middle aged man presents with SOB. O/E: AVF on Lt hand. Palpable thrill with ?? Systolic murmur on left lateral sternal border, not sure if it was diastolic murmur as AR. I said DD of systolic murmur as MR, VSD & TR.

Examiner asked if the murmur was pansystolic, early systolic or mid systolic.

He asked if palpable hepatomegaly, I said I did not check.

He asked for investigations and Mx.

I think I got it totally wrong.

Neuro: Middle aged female presents with dropping of things from hands. Please examine neurologically. Decreased muscle power on both hands more significant on rt, distal muscles wasting on hands marked on rt , reflexes reduced bilaterally, no proximal muscle wasting. Sensations normal in all 4 modalities. Normal alternate hand movement and finger nose tests.

I said dd: Distal muscle wasting, multifocal motor neuropathy with conduction block, MND.

The examiner asked UMN or LMN lesions, I said LMNL.

Then he said can it be polio? I said yes.

He then asked for investigations (NCT, EMG, MRI of spine) and management.

Examiner was not happy.

Communication 1: Talk to pt's son, 25-yr-old. 65 yr old pt with refractory M myeloma, 5 failed chmeo therapy. Recurrent h/o hospitalization for COPD and lung infections. This is the 4th time this yr, every times needed ICU & HDU admission. In every episode he never fully recovered. So both pt and med team agreed for DNR. This time med team wants to discuss End of life care and address any concern. Son asked why his father has recurrent lung infections and how long he will survive.

Abdomen : A fat man with AVF on Lt arm that was functioning, Rt lumber scar (which is old scar, kind of difficult to find unless paid special attention), bilateral ballotable kidney.

I said Dx: RRT most likely due to APKD.

LCC 2: 25-yr-old-man had RTA and hospitalized where CT incidentally founds 2 lesions on Lt adrenal gland. He was discharged as he was stable and told nothing wrong. Few days letter he received a call from hospital for urgent follow up to discuss the lesions he has on CT. His BP 120/70, Pulse 80, Spo2 98% Work On Paces I took detailed history, nothing positive, except father has cysts on kidney and currently on dialysis. I told him as he has no symptoms and his vitals are normal, at that point he is ok. However, he must need a regular F/U. I offered to check BP both on sitting & standing and, RBS. The examiner said normal. Examiner asked DD: I said Benign adrenal mass, adenoma, Mets, phaeo.

He asked me what further further investigations/Labs I would do : CBC, UnE, urine, USS of KUB (he laughed when I said USS, he said what u expect in USS where pt already did CT), Renin, angiotension, renal venous bl sampling. He was not happy. He asked what I look in UnE (electrolytes: Na, K) & what I will check in urine: I said metanephrine. He asked how frequent F/U and what investigations needed in future F/U: I said yrly full exam, and CT. Communication 2: 23 or 25 yr old young girl comes with headache for 6 months. Last few weeks got deteriorated. She takes paractamol (PC) for headache. She also has h/o teen aged migraine. The headache responded to PC previously but not working now. She has seen consultant who did CT which comes normal. So consultant diagnosed medication overuse headache. Task: Discuss CT finding and advise to stop analgesic. I discussed accordingly. Pt asked what she would do for pain? I advised life style and diet modification, weight reduction, relaxation. I assured that we will keep her close observation, in case she needs help. At that point I explored social factors: smoking, alcohol, job, birth control pill, stress in daily life, family support, recreational or herbal drugs. Work On Paces Pt asked whether taking PC was a wrong decision. I asked did her Dr/GP prescribed or she talk herself and dose? She said she took by herself, 4 times daily. Then I replied, yes, it was a wrong decision and she should always take med according to GP prescription.

Respiratory: Middle aged pt with SOB O/E: Bilateral clubbing, multiple scar marks on lower limbs due to old burn. Biphasic crepitations with few wheezes.

Examiner asked Dx: I said most likely Bronchiectasis, then asked why and causes.

He asked what is the single most important investigation and finding: HRCT, bronchial diameter is greater than adjacent blood vessels diameter.

Asked why this pt gets frequent infection: due to bronchial secretions.

What is the most important factor of management, I answered smoking.

Then he asked details of management including vaccinations and pulmonary rehabilitation.

****

Today Chennai diet 3 2023

I sit exam
CVS-AVR
CNS-cereballer
Respiratory- COPD
Abdomen- AVF With hepatomegaly

Long case 1-peripheral neuropathy (only right upper arm). D/Dx- Carpal Tunnel Syndrome

Long case2- melena stool (Aspirin induced)

Communication 1- viral encephalitis, for LP
Communication 2-BBN,Nutrition management(RT ,PEG)

***:;
CHENNAI CENTRE 🏮
Cc1: SOB, COUGH, WHEEZE 1 year
P/H TB, dx case of asthma since childhood, Finding rt sided fibrosis

CC2: 2 weeks pleuritic chest pain, H/O SLE
Low fever, wt loss, dry cough
Pleural rub present

St1a : LP counselling for meningitis
S1b: Brochiectasis, clubbing

St3a: Systolic murmur all over, with carotid radiation, AV fistula, apex shifted, volume overload,

S3b: BL Pyramidal lesion with vibration loss

S4a: female pt unable to get pregnant for 1 yr, on lamotrigine, asking to stop, thinking lamotrigine is the cause of infertility

St4b: ESRD due to ADPKD

*****
1/23
Good morning

My PACES experience

I started with station 4 , 5, 1,2,3

Station 4

Young lady admitted with excruciating sudden head ache with neck stiffness and CT scan normal, wants discharge against medical advise as she cam on business trip and has flight, I spoke about need of hospital stay and to do LP after 12 hours to rule out SAH and explained about seriouness of condition, she was convinced and I safety net her is she is willing , examiner questions went fine and lots of questions , details of management and asked ethical issues.

15/16

Station 5

Bcc1

diabetic neuropathy in elderly diabetic lady not on insulin, ask relevant questions about micro and macro vascular complications, did check peripheral pulses intact, pin prick sensations were in shocking distribution reduced, ankle reflexes were absent , I said diabetic sensory neuropathy, he asked anything else wanted to know b12 deficiency, lots of questions about management of diabetes, examiner happy.

27/28

Bcc2

Long standing bilateral knee joint pains and difficulty in climbing stairs, asked relevant questions to rule out sero + and - ve arthritis, denied all, examined showed bilateral swelling, not warm, I told ostearthritis , examiner happy , management, told analgesics, gastric protection and renal protection and life style modifications and knee replacement, he was happy.

28/28

Station 2

young man with 2 episodes of black out and recover but had incontinence of urine with prodromal and provocative symptoms, brother had history of epilepsy, gave d/D of vasovagal syncope, postural hypotension, cardiac syncope and neurogenic, took history in detail. Surrogate was not that professional, any way it went fine. Examiner was happy with d/d. I safety net the patient and addressed his concerns.

17/20

Resp

Young man with massive clubbing and bilateral coarse crepts all over, bronchiectasis, he asked causes , told all including cystic fibrosis and Yellow nail and management both nonpharmocological and multidisciplinary management. Investigations and all. Did well, examiner was happy.

20/20

Abdominal:

Bilateral flank masses and fistula working, happy with examination technique and asked management in detail. It was ADPKD ,asked ckd management, dd of bilateral frank masses, told all , happy.

20/20

Cardio

Middle aged man with right AV fistula , cold periphries, AF, apex displaced, psm @ apex with JVP raised, I told MR and d/D vsd and TR. Asked questions about Infective carditis , management, and investigations, did ok.

20/20

Neuro I was too tired

I examined lower limbs , left lower limb weakness with spasticity and hyper reflexes, noted facial deviation and left upper limb flexion, ask questions about management of stroke, answered but I didn't examine upperlimb . I dont know what he will do.

12/20

My experience
Chennai MGM
Started with st-2: 29 yr old male with 1st episode of collapse.

Inside - was in a long queue, last for 20 sec. Spont recovery. Urinate during the attack.
-VVS, orthostatic. Inv,mx

St3 cardio- ESRD With fistula in rt arm.
MR with AF. Probably ischaemic MR. Inv,management.

Neuro: examine the patient neurologically. Ask to walk but pt cant walk. On examination left sided hemiparesis with lt 7th CN palsy.
Crossing mainly inv and management

St4: Pt with headach, suspected SAH. CT negative. Consultant asked for LP.
Examiner asked me did i checked for mental capacity? I told yes. How? I told at the beginning i explained her condition she understood, and recalled, after deciding pros and con she agreed to do LP.
Examinner reply - is it presumed capacity?!

St-5: (night mare)
Both surrogate were stupid enough to spoil the exam. They memorized few word at the beginning they spit it out within 1 min then each and every questions answer is no. Also pt and surrogate gave different answer for same question!

BCC1: p.neuropathy, pt is diabetic for 15 yr.Hidden **issue pt is vegetarian**
Missed it.

BCC2: out side lt knee pain 3 yr
Inside both knee. D/h bblocker+ one more medicine dont know name.
More for last 3 month.

OA, gout, pseudogout.

Pain increased for 3 months, he had h/o low grade fever for 1 week. From crossing it seems they are expecting reactive arthritis.

St: 1
Resp. Young boy around 20. clubbing
B/ l creps and rhonchi.
Bronchiactasis- CF, and other DD.
Crossing on inv and management.
Abdomen: ADPKD with fistula. B/L kidney.

*******_
Diet 1 2023 Chennai..sundaram foundation

St1-RA with COPD

Post renal transplant with ascites

st3-cvs..?not sure midline sternotomy scar,pulmonary htn,split s2

Cns-multiple sclerosis,cerebellar stroke ,FA discussed

St2..young female,unsteady gait,dizziness 2 days Post bariatric surgery 6 weeks,alcoholic.

St5 bcc1-middle aged man with joint pain 3 months…inside psoriatic rashes +

Bcc2-young man loose stools and abdominal pain since 2 months

St4-
Mtx on psoriasis started trimethoprim & developed pancytopenia -medical error.

1/23
Cardio MR
Neuro leprosy

Respi bronchiectasis
Abdominal ascites av fistula

History pedal edema

Bcc1 pedal edema
Bcc2 raised icp

Communication : Missed X Ray

Medicine overuses headache plus tension in history.

Starting steroids for ulcerative colitis station 4,

bcc
psoriasis,
glomerulonephritis.

Cvs she had midline sternotomy scar, no clubbing , S1 loud , not in af , plus pulmonary hypertension I gv diagnosis it could be ms , they asked about Ms and pht management,

CNS - stroke left UL and lower limb , left sided facial nerve also , I told mca lesion mostly asked management and investigation, abd was easy apkd bilateral mass felt and on av fistula , they asked management.

Rs - clubbing present crepts plus increased VF VR on left interscapular region
gave dd bronchiectasis and COPD they asked management.

Today's cases in Chennai

BCC -
neck swelling,

young uncontrolled HTN

Post polio syndrome
Pneumonectomy
ADPKD

History - Anaemia (NSAID induced gastritis/ IBD)

Ethics - deliberate self harm

This is from Sundaram medical foundation

BCC :
Blurring of vision + FALL in elderly male
ADPKD

Prosthetic aortic valve
Cerebellar ataxia

COPD
CKD + Hepatomegaly + ascites

St 2 headache - migraine

Another

Effusion & trachea shift
ADPKD + Fistula

Rt hemiplegia without facial palsy

History - hematuria - ADPKD

Communication : Meningococcal meningitis

BCC 1 : Diarrhoea, food +
DD infectious

BCC,2 : childhood asthma, now uncontrolled. Dd copd

Chennai 1/23

St 2 headache... Migraine GCA, cavernous sinus thrombosis, are differentials

St4 anaphylaxis with peanut allergy

St5 vision loss with fall with DM... PDR pt on fundus

St5 back pain young pt with renal stone and pyelonephritis..... Adpkd pt with actually inside left side loin pain....

St3

aortic valve replacement no murmur with no signs of IE

Peripheral sensory motor neuropathy with cerebellar signs..... DD hypothyroid alcoholism B12 and hereditary spinocerebellar ataxia

St1
CLD with portal HTN with AV fistula for renal replacement therapy.. Hepatorenal syndrome.. Obstructive airway disease COPD INFECTIVE exacerbation right upper zone consolidation.....

Another

Cvs pulmonary htn
Lt hemiplegia

St 2 hemiplegic migraine

St 4 occupational asthma

Bcc
vasovagal syncope

Htn, ckd, knee pain

Tanjima Mitu apu

carousel 1:
St 2:
38 yrs old male,Ankle swelling, 3 weeks, joint pain small hand joints with morning jamming, SOB in the scenario but surrogate said no!!!, urinalysis protein 3 +, past H/O MI, treated with stenting, now medication : aspirin, bisoprolol, atorvastatin, OTC- ibuprofen for joint pain,Father has MI, mother had arthritis,recent wt gain 2/3 kg

D/D :
NSAID induced nephropathy,
SLE with lupus nephritis,
secondary GN

St :3-
Cardio : MS with AF with Pul HTN

Neuro: Rt sided hemiparesis with NG Tube, cannula, Pulse oximeter (totally unstable pt, can't co- operate!)

St4: breast cancer treated, now suspicious CXR, 6 weeks back, angry pt, why the doctor didn't tell her the reports and discuss further management plan

St:5

BCC-1 recurrent falls
DM, HTN

BCC2: left arm pain with fever
Dx- thrombophlebitis of AV fistula

St1

Resp: COPD with bronchiectasis

Abd: hepatosplenomegaly with deep jaundice

****
MY EXAM IN CHENNIA MADRAS MEDICAL
MISSION 12NOV 2018

I begin with st2
A young patient with asthma since childhood. 3 month resistant to treatment with rash at both legs
DD occupational asthma charus stress
CV patient with chest pain on exam
pancystolic murmur radiate to axilla also radiate
to neck DD AS MR

NS . elder patient ask for gait examinar not
need left leg power weak tone increase
babinisk eqivocal i want exam upper limb
examinar no need i observe left hand weaknes
when ask patient for reinforcement for rt ankle
jerk diag lt hemiplagia where lesion difficult
could be i go to roung diagnosis

ST4 traxi driver with TIA explain to him
disease stop driving .
st5 cc1 lady with bilateralleg edema progress
with few days nothing in history juist in past
history DM for 20 years on exam leg edema

posative ,cataract blind diabetic nephropathy
CC2 patient with diarrhea eating outside
home3days ago concern want to traveal for
wedding her brother
Abdomen patient wiith av shunt with
hepatosplenomegaly ,

CHEST :patient with sob.
exam left side back, decreased air entry. dullness coarse crackles

DD effusion, bronchiectasis.
examinar ask about pleural effusion. causes, diagnosis, light criteria for pleural effusion
treatment of TB.

*****
PACES CHENNAI NOVEMBER 12 2018
MANDAI MEDICAL MISSION

ABDOMEN
Enlarged kidneys: APKD on hemodialysis via Left AVF
Was asked what vaccinations ESRD patients need

RESPIRATORY
Bronchiectasis: chesty cough, bilateral crackles

NEUROLOGY
Upper limb: old stroke hyperreflexive, increased tone

CARDIOLOGY
ESM with slow rising pulses: Aortic Stenosis

HX TAKING
25/F come in for followup from apparent
anaphylaxis from seafood

COMMUNICATION
Speak to son RE his father with esophageal
stenosis, post esophageal dilatation #3
developed esophageal perforation.
Was asked what my plans were and if pt can go
home or not

BBC1
Seizures in a young epileptic male with HTN. Was asked what could cause the seizures.

BBC2

Progressive Blurring of vision in 68 female with DM HTN Hyperlipidemia. Saw she got cataracts, then i didn't do well on fundoscopy. coz not sure about retinal findings.

****
MY EXAM IN CHENNAI MADRAS MEDICAL MISSION
12 NOV 2018

#Station2
A young patient known as bronchial asthma since childhood.
For the last 3 months he is resistant to
treatment with rash on both legs DD
occupational asthma churg straus

#CV patient with chest pain on exam
pansystolic murmur radiates to axilla also
radiate to neck DD AS MR

#NS
An elderly patient, No need to examine the gait.

left leg power weak tone increased babinisk
equivocal
request to examine the upper limb examinar no
need i observe left hand weaknes when ask
patient for reinforsment for rt ankle jerk
diag lt hemiplagia where lesion difficult. Not
sure of diagnosis
#ST4
A taxi driver with Tia. Task: explain to him
disease & to stop driving

#Stn5
BCC1: A lady with BILATERAL LEG edema progress within few days.
nothing in history just
in past history DM for 20 years on exam leg
edema ,cataract blind diabetic nephropathy

BCC2 patient with diarrhoea.

eating from outside home 3 days ago. concern want to travel for
brother's wedding

#Abdomen patient with av shunt with
hepatosplenomegaly

#CHEST patient with sob exam left side back
decrease air entry. dullnes & coarse crackles

DD effusion bronchiectasis. examiner ask about pleural effusion causes, diagnosis , light criteria for pleural effusion treatment of TB

*****
passed my exam in Chennai no diet 1 2018
..159/172 my exam experience as follow :

Start withstation 2 :

young age female with type one DM present.
With weight loss and tiredness
Examiner ask about DDx ..
DDx : Hyperthyroid ism , Addison disease ,
celiac disease got 20/20 .
Station3 :
Cardiology . Mitral valve replacement .. ask
about causes of sob in this patient ... got 20/20
Neurology : Left sided hemiplegia .. ask
diagnosis and management got 20/20

Station 4:
Worst station : talk to son about his father
condition present last week with SBP and
hepatic encephalopathy got 7/16

Station 5 :

BCC1 .. neck mass .. ask about DDx and
management.

got 28/28

BCC2.. fever for 1 month duration ..
Ask about Diagnosis and investigations
. got 24/28

Station 1 :

Respiratory: Old pulmonary TB .. ask about DDX
management got 20/20

Abdomen : ESKD with Renal transplant .....
Asked about DDX and management.

got 20/20
******
Chennai :Sundaram Medical Foundation Diet
2018/01 2nd Day 2nd Carousal

Started with BCC1: outside: Skin rash with joint pain
Inside:Psoriasis with Psoriatic Arthritis with nail changes.Hypertensive getting ACEi.
Qus:
Diagnosis,Investigations,Management,Prognosis.
Got :28/28
BCC 2: Outside: Young male with abdominal pain and loose motion for 3 month
Inside: wt loss,no relationship with food,milk,no joint pain, red eye,painful eye,no travel history.watery diarrhohea,no blood,no slime.Positive history for multiple sexual partners,no sore throat,lymphadenopathy,no oro genital ulcer,no urethral discharge,tenderness in right iliac fossa.wt loss 2 kg in 3 month.no history of antibiotic use,or contact with TB person,no postural drop.I gave DD: HIV enteropathy,IBD,CD & other malabsorption. qus: 1.What stool examinations?2. If you find ulcer in colonoscopy then what you will do? 3. How you test for HIV? 4. If HIV serology is positive will you start HAART?
Got:28/28

Abdomen: ESRD,Active Fistula,ADPKD ,Anaemia. qus was : Investigations,Cause of Anaemia,Treatment of Anaemia,Dose of EPO and how to administer. Got 18/20(May i didnt mention about enlarged cystic liver)
Respiratoty: Bronciectasis with COPD .Qus: Positive findings,Investigation,Management,If the pt comes with massive hemoptysis what you will do?I said I will admit the pt in ICU,urgent Blood grouping and cross matching and involvement of respiratory team and management of ABC.Got 20/20.
Station 2: young female with history of fall and urinary incontinence and positive family history for epilepsy.Diagnosis: Vasovagal syncope,DD: Cardiac syncope,TIA,Hypoglycaemia,Seizure.Concern: Driving.
Qus: Inv and management .Got 20/20.
Cardio: Middle aged female.Positive findings: AF in rate control,mitral vulvuloplasty scar,loud

S1 with variable intesity,bipedal edema.Lady was fat so didnt mention about apex beat.Plus there was no audible murmur .Qus was around MS,Investigations,management .Got 20/20.

Neuro: to me it was UMN type of VII the nerve palsy as the lady can frown and close her eyes tightly and lower half of face was involved.No scar mark no vesicles,no long tract sign,no cerebellar signs. Qus was around both UMN & LMN type lesion. Got: 8/20 (It was KMN type).
Station 4: young female recently diagnosed with ADPKD,Father has ADPKD on MHD,poor quality of life.Planning to get married.Worried about future kids,brothers,whether to tell her fiance,will she need dialysis and lead a miserable life like father. Got 16/16.
Alhamdulillah Passed in the first attempt with 158/172.

******

By the grace of Almighty Allah I've passed PACES on my 1st attempt in 2018/1 diet from Chennai Madras Medical Mission Hospital...
Started with st 2: middle aged man presented with recurrent collapse. Known case of T1 DM with all microvascular complications and all features of autonomic neuropathy..history was not so typical of hypoglycemia..past history and drug history revealed he was on multiple medications like beta blocker, ACEI, diuretics, warfarin, insulin,..my D/Ds were hypoglycemia due to diabetic autonomic neuropathy, cardiogenic syncope, postural hypotension due to drugs and autonomic neuropathy, hypoadrenalism..
Concerns were about driving, family planning as he had erectile dysfunction
Crossing was on management, investigations, consequences of syncope in his case and causes, DVLA rules,
Got 20/20 ☺
St 3: cardio was ms+mr+af+pulmonary hypertension
Crossing was on inv, mx, af, anticoagulation, complications
Got 20/20☺

Neuro was hemiparesis with umn 7th.. went smooth. Patient had aphasia and walking aid besides his bed
Crossing on dd, inv, mx, thrombolysis, thrombectomy, young stroke..
Got 20/20 ☺
St was to convince a lady for lp who wants to travel to usa..I was able to convince her partially.. offered 2nd opinion
Got 16/16☺

Bcc 1: neck lump, euthyroid, lump increasing in size..

Concern was about the possibility of cancer..Crossing was on d/d, inv, mx, MEN 2

Got 28/28☺

Bcc 2: young lady with right loin pain with features suggestive of UTI..excluded stone, cysts..

Concerns were about possibility of ectopic pregnancy..menstrual history did not suggest that so i told it's unlikely..

Crossing was on Dr, inv,mx, ectopic pregnancy!!

Got 27/28?

St 1: respi: I gave dd as copd with infective exacerbation / bronchiectasis
Crossing was on every details of dd, inv, mx, complications
Got 20/20 ☺
Abd: Esrd with adpkd on HD..
Crossing was on esrd, adpkd, dd, mx,
Got 20/20
Passed with 171 Alhamdulillah..

****
passed from Madras Medical Mission Hospital, Chennai in 2018/01 diet with the score of 154/172.
My exam started with Station 5
BCC1- 40 yrs old lady came with fatigue, CBC showed low Hb.
She gave history of menorrhagia only, I asked her about features of hypothyroidism, all bleeding disorders, family h/o, drug h/o,

occupational h/o,details menstrual and obs h/o but there was no clue. Only h/o wt loss.
General examination , skin survey were normal.Abdomen was a little distended but no organomegaly.
My dx was fatigue due to anaemia as a result of menorrhagia possibly due to gynaecological malignancy.
Question were on inv , mx and referral to Gynae and obs.
Score 27/28
BCC2- 40 yrs old lady, known case of epilepsy for 12 yrs came with one attack of seizure

I took h/o to establish true seizure, there was h/o party the night before attack, also had h/o vomiting and missed a dose of phenytoin.No h/o recent fever,no other h/o precipitating coz for seizrure, no h/o low IQ or skin lesion, no h/o symptoms suggestive of ICSOL
Examination revealed no abnormality
Questions was coz of attack, inv , mx
They asked me whether I have checked side effects of phenytoin, I didn't do it.
Score 22/28

Station-1

Abdomen: ESRD due to ADPKD with renal transplant with av fistula.I thought there were multiple av fistula but in reality there was one fistula which got engorged in 3 different sites , examiner was kind of rude and wasn't helpful.
Score 11/20

Respiratory: Rt sided upper lobe fibrosis with Obstructive Airway Disease
Questions were about inv, mx, how to manage him if he gets admitted with SOB, steroid can be given or not in this case if it is post TB fibrosis
Score:20/20

Station 2
Young male presented with low back pain....
Gave positive h/o inflammatory back pain, one skin rash behind ear and had issues regarding job as he was a cleaner. Bowel habit was normal.no h/o exposure, uti , no h/o exra articular manifestation of Sero negative

arthropathy.
My d/d Psoriatic spondyloarthopathy, Ank.spondilytis
Questions about Inv, Mx.
Score 20/20
Station 3
CVS: Mixed Mitral valve ds with predominant MR with AF with pulmonary HTN
Question about inv, Mx ,Newer anticoagulants name, whether they can be given in this case or not
Score 18/20

CNS: Young male has come with walking difficulty, examine his LL. On examination he was a case of lt sided Hemiplegia.
Question about possible cause of hemiplegia, if it is stroke which area is involved, how to inv and mx
Score20/20
Station 4
Talk to angry son whose mother was diagnosed with GCA on the basis of severe headache when she was at a rehabilitation centre after surgical treatment of femur fracture, was given high dose steroid and developed psychosis.Later he was tranferred to hospital and it was found that she wasn't a case of GCA and steroid was stopped.
Score 16/16
I was really upset about the unusual cases of station 5 and also examiner wasn’t happy at all at Abdomen station.But the Almighty ALLAH blessed me and I passed the exam in 1st chance.
So ALHAMDULILLAH!!

******
Chennai Diet 1 2018 Madras Medical Mission
St 4 70 yo F admitted for hip surgery and recovering well in rehabilitation unit suddenly had Headache. Attending doctor started her on steroids suspecting GCA, after which she developed steroid psychosis. She was taken in the main hospital building under medical team and the son was not informed. Task was to talk to angry son.
Cross was about whether it was negligence.

Complaints procedure.

St 5 BCC1
40 yo F came to AE feeling faint. Her GP did some test which revealed Hbs 7.8(roughly can't remember the exact number)
MCV 65

Inside I found only menstrual abnormality which I didn't probe further , as I was hurrying to exclude other DDs. Pt had no anaemia.

Gave DD of possible causes of anaemia
including gynaecological problems.
Cross was with inv, mx.

BCC2
45 yo F with seizure and diarrhoea for last 1 dayKnown case of epilepsy , forgot to take medicine due to illness. Diarrhoea for 4 days which showed no correlation with seizure or drug.

St1
Abdomen
Middle aged male ESRD or with renal transplant
and AV fistula.
I was confused with liver as I thought I found
hepatomegaly.
Cross was on why hepatomegaly , Inv, mx.

Resp
It was a very confusing case for me. A middle
aged F , found only rhonchi, and crepts at both
bases which were not typical bronchiectasis .
Gave dd of asthma, copd with IE , bronchi
Cross was on inv, mcg.

St2.
30 yo M with fatigue and back pain.
Inside was sspA psoriatic.
Cross was in on DD, inv, mx.

St3
MS with pul htn with AF
Usual cross on inv finds, complications, mx
HSMN

Cross on dd, inv, Mx.

Got full marks in st2, 4,3, bcc 2.
St1 and bcc 1 were not smooth and lost marks.

Alhamdulillah passed.

*****
My PACES experience
Chennai Sundaram Medical Foundation diet 3/2017

Started with station 5

BCC1 psoriatic Arthropathy ,questions about differential,investigation and management...patient already on treatment with methotrexate for psoriasis.28/28😊

Bcc2 male middle aged banker with hemoptysisand shortness of breath one month…

inside on
history taking, no fever but give history of weight loss and is chronic smoker 40 pack year...examination no finding.

Gave probable dx as bronchogenic carcinoma but wanted to rule out TB

Questions regarding any finding,investigations.

and bell rang27/28.☺ALHAMDULILLAH

Station 1 shortness of breath,
Patient having left thoracotomy scar with decreased breath sounds and VR in left lower lobes question with findings and reason for lobectomy ..gave TB as probable ...couldn't point out cause for it 12/20?

St1 abdo male with AV fistula left forearm functioning with hepatomegaly (smooth)3 finger ...no scars
Gave ESRD on MHD with hepatomegaly .... questions on reason for ESRD and for hepatomegaly...didn't say about ADPKD {smooth margin not cystic)😢14/20
St2 female with angioedema no precipitant,adopted child , recurrent abdominal pain led to appwndicectomy but pain recurs,,this is repeated scenario also given in Ryder ...gave provisional as hereditary angioedema differential of anaphylaxis

questions about investigation,diagnosis ,
management and advice to patient...I thought
didn't answer
viva well but Alhumdulillah 19/20
St3 CVS my night mare...
Young male ,bradycardia I thought sinus rhthym
,no scars ,no murmurs😳😳only heard loud S1
...gave dx as MS..viva on silent MS,complication
of MS ,,leading toward AF management of AF
but bell rang 10/20

CNS old gentleman looked cva..
But not cooperative ...command was to examine
him neurologically didn't read properly thought
only lower limb after motor wanted to do
sensory on lower limb examiner said no need
then gait ::circumduction gait left hemiparesis
...asked permission to examine upper limb 🙈1
min left ....{should have done only motor exam
ul and ll and cranial nerve}couldn't complete
upper limb viva on findings , investigation
choice between ct and MRi if present at 30 mins
after weakness and other investigation 17/20

St 4 case of young female physiotherapist
assistant with probable functional
weakness....variable findings in clinical exam
,CT normal,Neurologist seen and advise MRI
which is also normal {patient doesn't know
result}meanwhile a nurse told her that doctors
think she is faking it,patient angry and upset
wants to see the good neurologist who seems
to understand her😏task to speak to her about
the provisional working diagnosis of functional
weakness ,and explain further plan🙊
Spoke to her appreciating her concern that
anybody will feel bad if people think they are
faking it...she kept asking for the neurologist
explained he will b seeing her later in the
day...tried to know any precipitate events...she
has stress at work place she is physio asst in stroke ward afraid she will end up
paralysed...at
home doesn't so well with mother ,,grandmother
was close to her but she died recently ....told
what she is undergoing is distressing,doesnt
mean she is faking but given that ct ,MRI normal
it's good news and stress can cause this in
some people..explain need to speak to

behavioural psychologist ...used psychiatrist
also examiner questioned who is better
psychologist or psychiatrist said
psychologist...can she have stroke....said stroke
in young possible but not this patient as
clinically and imaging wise she is fyn and has
stress at work and home
16/16 Alhumdulillah

MashaAllah laquwwata illabillah
JazakAllah khairan
Total score 143/172

*****
PACES EXAM EXPERIENCE
St 1 : abdo :
ESRD on active dialysis from AV fistula ... has
large lt hypochondrial scar (?)
looks cushingoid
Chest :
ILD in cachectic patient with porta cath beneath
skin below rt clavicle + amputated fingers and
amputated leg (below knee) ... asked about DD
and what could be causing ILD.
Patient has portacath because taking IV
medications repeatedly.. why and which
medications ?
St 2 : wageners
Has upper and lower respi + nasal discharge +
dark urine + joint pains ... etc
St 3 :
Neuro : Rt upper limb weakness and hypertonia
.. discussion about stroke
CVS : double mechanical (both aortic and
mitral) St 4 : C. Diff following pneumonia ttt in 83 y old
lady ... son angry because doctor didn't wash
hands (repeated well known scenario) and want
to complain about doctor.
BCC 1 : outside microscopic hematuria ...
Inside : joint pains and gouty arthritis .. gave DD
of uric acid stones and ibuprofen induced
interstitial nephritis

BCC 2 : fatigue and blurring of vision ... inside :
optic atrophy (?)

BCC2 May be myasthenia gravis

*****
I pass my exam in chennia India-- Thank good
It was tough one with very atypical clinical stations
I started with station 1
Abd : middle age male with active fistula + LL odema
No signs of fluid over load
Not on anti rejection Med
Ploysystic kidney disease
With cystic liver
Q.1 what is ur diagnosis
Q.2 did u see the rash ?? now clue if there was any
Q.3 what can cause liver cirrhosis in this pt 😅😅
)worst station got 14/20 (

I think the rash is lichen plans with HCV I do not know
:Resp
Middle age man again active fistula
With hyperinflated chest
Tar stain in fingers and teeth
With no wheezes only fine Basel crip
Not changing with coughs
Q.1 what is ur diagnosis
Copd with lung fibrosis
Q.2 how would you like to investigate Q.3 any
relationship between his lung problems and dialysis
First thing 😔😔 may be Med then saved by the bell 🔔
one of the examiners was sitting on his chair at the (
foot of the pt
I asked him to move politely and even moved his chair
to sit far away 😅😅😅
Station 5
I was happy 😊
st case 1
Unilateral limb swelling
All vitals are stable
I put diff of cellulits + rupture beacker test
And I entered
To very young male
Again on dialysis 😗😗 with permicath
With chronic limb swelling over 5 years
Pain less with strange knee joint
?? No history of insect 🐜 bite
I examined the limb
Slightly pitting
Not hot or tender I examined inguinal
LN ???
I asked pt to walk then sensation
Examiners escip and normal respectively

There was parathyroid scar
Concern by relative
is it related to dialysis should we increase the the)1
dialysis frequency
I answered not related and best to talk to your kidney
specialist if you have any concerns regarding dialysis
What is the cause)2
It most likely due to lymphatic obstruction
We need to start to do some test to know exact cause
😌😌😌😌 and he do not need admission
Examiners
Q 1.what is cause of swelling
Lymphodema
Q 2. How would you like to investigate him
Stupid answer lymphogram
What might be the cause in this country
With more stupid smile
Chagass disease (how stupid you may become in exam
Totally forget flaria) where Chagas come from
Saved by bell 🔔
Got 18/26
nd case2
Totally straight forward
Bilateral limb swelling in HTN
I put differential
Then went to role out serious complication of HTN
There is decrease frequency of urination
With drug history on
Nefedipine for one year
Complain also from ? headache
Plan of management
Admit the pt
Switch nefedipine to other Med
Doing some test and scan to ur kidneys
Those were the answer of the concerns
Examiners
Q1. How to mange pt
Education, stop medications switch to other Med,
elevation of the foot
Q2. What Med you will give pt
I said ACI
Why not diuretic
I said not recommend as pt having dependent odema +
there no evidence of fluid over load
Station 3
Cardio
Middle age female again active fistula in right arm
Exam

Obvious Lowe limb edema
Raises JVP with v wave
Obvious apical pulsation
No thrill ,LPH
Irregular pulse
Loud s1
Could not ass the 2 heat sound coz of the fistula thrill (
)which irritates the examiner 😂🤣
Diastolic murmur in apex
And hypothetical tricusp reg
Q1.what is ur diagnosis
Q.2 what r the causes of MS
Any congenital MS syndrome you know
I answered lutinbaker 🙃🙃🙃
Got 13/20
CNS
Straight forward
Pt presented with dysphasia
Examine LL
Young male with CVA posture
Q.1 what is the lesion
)Q.2 where is the lesion (subcortical
Q.3 how to investigate and mage
Indian male not understanding English lot of time (
missed in translations, I couldn't not ass the pulse
heart or cranial nerve or ask pt to walk but I told
) examainr I want to do so
Luckily I got 20/20

Station 2
History
Middle age female newly diagnosed HTN
With persistent high reading
Approach with systemic manners
No symptoms suggestive of end organ damage
No symptoms of all secondary causes of HTN
Reached gynecology history
Pt was having irregular menses with prescribed OCP for
1 year
No other important history
after I reached concern I remembered to ask (
biological family if the pt was adopted (APkD) as in
) DR.zain scenario
Concerns
Do I need to take Med for life .1
Ans as your HTN probably due to Med there is a good
chance it might be temporary
will it affect me having babies.2

Ans. High Blood pressure may serious with pregnancy multi desplinary team involving pregnancy specialist and your physician would keep a good eye over it
Plan of management

Stop the OCP , seek alternative with the help of ur pregnancy specialist
We will do some test and may be scan to ur kidneys to see the extend of ur disease
Examiners questions
Q.1 what is ur diagnosis and differential
Q.2 what is common-cause in this country if it is renal cause
I answered post streptococcus GN
I got 20/20
Common scenario=Station 4
Young male with ulcerative colitis un controlled with mesalazine
With inc diarrhea and weight loss
Council pt regarding steroid
Started with open questions
Then pt afraid. From steroid as he read about side effects
Then I filled the gaps
Then every complication how we might mange
Involved the GP
Conserns
for how long you will use steroid)1
Ans
Until we control the disease the dec dose till we reach remission with minimal dose
I want to use herbs 🌿)2
Ans
Sorry but I can't be sure what will be the effect on 🌿 on the disease course or how it may interact with steroid
If u choose to use herbs 🌿 plz inform ur GP
DR.zain advice never say no to stupid thing pt want (to do just smile and give all options to him and then till)him ultimately you may hurt your self
Discussion
What is ethical issues
What are the complications of ulcerative colitis
anemia)1
Which type
All type
)Norm normo (of chronic disease
)Megaloblastis (fe + b12 malabsorption

)Iron deficiency (due to blood loss
colorectal Ca)2
This what he want to hear
what kind of diet you will give him)3
I tried to be smart ??? I will refers to dietitian
Then agin what diet
I told him high fiber diet 😆😆😆
He asked me ru sure 😅😅😅
I said with smile of ignorance
Yes sure
I got 20/20

****
My exam experience in chennai today 3/4/17
Station 2
History taking of cough and shortness of breath for 6 months. She has fever on and off but no night sweating weight loss of 6 kg within 6
Months. No wheezing she works in printing company and her colleagues have also cough which she is thinking due to printing materials they use all cardiovascular history is negative. No history of TB contact no HIV risk factors. she receive many
.antibiotics without improvement
I put differential of TB and lymphoma and asthma. During childhood she has asthma which improved. Not smoker or drinker. But unfortunately the diagnosis was
.extrinsic allergies alveolitis. I miss birds at home
Station 3
.Mitral stenosis with AF it was clear
Neuro
Is parkinson plus CVA. Rigidity only on distraction so I put parkinsonism plus CVA reflexes was exaggerated
.on the right upper limb only no tremor
Stations 4
.Easy case explain renal biopsy for SLE patient
Station 5
Difficult young on phenytoin developed seizures yesterday after history of vomiting once and loose
.bowel four times
.I don't know the case
Second case history of bilateral knee pain with stiffness less than 10 minutes. It was osteoarthritis no other significant history of skin rashes or other joint problem
.except back pain occasionally
Stations one
Polycystic kidney and clear function fistula on dialysis. Polycystic kidney is common in chennai take care it

..mimics hepatosplenomegaly
.Chest I don't know it
pray for all candidates in chennai please
i hv passed paces this diet..i hv already shared my experience before..i just want to share my notes i hv prepared by myself.. i prepared all that notes by help of books, Dr. Ayesha audios and most importantly by guidance of Dr. Rashmi kushal (Owner of paces ahead and examiner of paces exam) during attending the course... all of these regarding preasentation of st 1 and 3
****
Chennai (3.4.2017) 1st round
History loose motion 6 months GP IBS.
Communication delay Dx phaeochromocytoma.
Bcc.Abdominal pain for 2 days, fever and oligiuria known DM. ddx
Visual impairment in DM pt... dx: cataract
CNS: Lt hemiplegia
CVS: systolic murmur with AVF machinery murmur
Resp: LL BBS+crep ddx think lower zone fibrosis or consolidation
Abd: Ascities+AVF think ESRD with (RRT) fluid overload.
Resp: bronchiectasis/pneumonia.
CVS: Systolic murmer: PS/ASD/ WITH MS.
CNS:STROKE WITH PERIPHERAL NEUROPATHY.
ABD: ASCITES WITH FISTULA
Chennai Day 1 -11.45 am cases
Pheochromocytoma telling the diagnosis to patient station 4.
Bcc 1 diabetes and UTI, bcc2 diabetes and loss of vision - funds examination.
Abdomen ckd with HSM. Resp left upper lobe fibrosis. History 6 months altered bowels and abdominal pain. Cardioloy AS / HOCM ? Associated MR also. Neuro b/l cerebellar signs with absent reflexes .. best of luck to all of you
Chennai (3.4.2017) 3rd round
history. Cough for 6 mts SOB. Bird fancier lungs.
Com. SLE renal biopsy.
BCC1 seizures.
BCC 2. knee joint pain OA!
(Copied) My exam experience in chennai today 3/4/17
Station 2
History taking of cough and shortness of breath for 6

months. She has fever on and off but no night
sweating weight loss of 6 kg within 6
Months. No wheezing she works in printing company
and her colleagues have also cough which she is
thinking due to printing materials they use all cardiovascular history is negative. No history of TB
contact no HIV risk factors. she receive many
antibiotics without improvement.
I put differential of TB and lymphoma and asthma.
During childhood she has asthma which improved.
Not smoker or drinker. But unfortunately the
diagnosis was extrinsic allergies alveolitis. I miss birds
at home.
Station 3
Mitral stenosis with AF it was clear.
Neuro
Is parkinson plus CVA. Rigidity only on distraction
so I put parkinsonism plus CVA reflexes was
exaggerated on the right upper limb only no tremor.
Stations 4
Easy case explain renal biopsy for SLE patient.
Station 5
Difficult young on phenytoin developed seizures
yesterday after history of vomiting once and loose
bowel four times.
I don't know the case.
Second case history of bilateral knee pain with
stiffness less than 10 minutes. It was osteoarthritis no
other significant history of skin rashes or other joint
problem except back pain occasionally.
Stations one
Polycystic kidney and clear function fistula on
dialysis. Polycystic kidney is common in chennai take
care it mimics hepatosplenomegaly..
*****

I pass my exam in chennia India
It was tough one with very atypical clinical stations
I started with station 1
Abd : middle age male with active fistula + LL odema
No signs of fluid over load
Not on anti rejection Med
Ploysystic kidney disease
With cystic liver
Q.1 what is ur diagnosis
Q.2 did u see the rash now clue if there was
any
Q.3 what can cause liver cirrhosis in this pt 😅 😅

(worst station got 14/20)
I think the rash is lichen plans with HCV I do not know
Resp:
Middle age man again active fistula
With hyperinflated chest
Tar stain in fingers and teeth
With no wheezes only fine Basel crip
Not changing with coughs
Q.1 what is ur diagnosis
Copd with lung fibrosis
Q.2 how would you like to investigate Q.3 any relationship between his lung problems and dialysis
First thing 😔 😔 may be Med then saved by the bell 🔔
(one of the examiners was sitting on his chair at the foot of the pt
I asked him to move politely and even moved his chair to sit far away 😅 😅 😅 got 17/20
Mohamed Fadel
Station 3
Cardio
Middle age female again active fistula in right arm
Exam
Obvious Lowe limb edema
Raises JVP with v wave
Obvious apical pulsation
No thrill ,LPH
Irregular pulse
Loud s1
Could not ass the 2 heat sound coz of the fistula thrill
(which irritates the examiner 😂)
Diastolic murmur in apex
And hypothetical tricusp reg
Q1.what is ur diagnosis
Q.2 what r the causes of MS
Any congenital MS syndrome you know
I answered lutinbaker 🙃 🙃 🙃
Got 13/20
CNS
Straight forward
Pt presented with dysphasia
Examine LL
Young male with CVA posture
Q.1 what is the lesion
Q.2 where is the lesion (subcortical)
Q.3 how to investigate and mage
(Indian male not understanding English lot of time

missed in translations, I couldn't not ass the pulse
heart or cranial nerve or ask pt to walk but I told
examainr I want to do so)
Luckily I got 20/20
Mohamed Fadel
Station 4
Common scenario
Young male with ulcerative colitis un controlled with
mesalazine
With inc diarrhea and weight loss
Council pt regarding steroid
Started with open questions
Then pt afraid. From steroid as he read about side
effects
Then I filled the gaps
Then every complication how we might mange
Involved the GP
Conserns
1) for how long you will use steroid
Ans
Until we control the disease the dec dose till we reach
remission with minimal dose
2) I want to use herbs 🌿
Ans
Sorry but I can't be sure what will be the effect on
🌿 on the disease course or how it may interact with steroid
If u choose to use herbs 🌿 plz inform ur GP
(DR.zain advice never say no to stupid thing pt want
to do just smile and give all options to him and then
till him ultimately you may hurt your self)
Discussion
What is ethical issues
What are the complications of ulcerative colitis
1)anemia
Which type
All type
Norm normo (of chronic disease)
Megaloblastis (fe + b12 malabsorption)
Iron deficiency (due to blood loss)
2) colorectal Ca
This what he want to hear
3) what kind of diet you will give him
I tried to be smart I will refers to dietitian
Then agin what diet
I told him high fiber diet 😆 😆 😆
He asked me ru sure 😅 😅 😅
I said with smile of ignorance
Yes sure

I got 20/20
Mohamed Fadel
Station 5
I was 😁 😁then 😵 😵 😵
1 st case
Unilateral limb swelling
All vitals are stable
I put diff of cellulits + rupture beacker test
And I entered
To very young male
Again on dialysis 😗 😗 with permicath
With chronic limb swelling over 5 years
Pain less with strange knee joint
No history of insect 🐜 bite ??
I examined the limb
Slightly pitting
Not hot or tender I examined inguinal
LN
I asked pt to walk then sensation
Examiners escip and normal respectively
There was parathyroid scar
Concern by relative
1) is it related to dialysis should we increase the the
dialysis frequency
I answered not related and best to talk to your kidney
specialist if you have any concerns regarding dialysis
2)What is the cause
It most likely due to lymphatic obstruction
We need to start to do some test to know exact
cause 😌 😌 😌 😌 and he do not need admission
Examiners
Q 1.what is cause of swelling
Lymphodema
Q 2. How would you like to investigate him
Stupid answer lymphogram
What might be the cause in this country
With more stupid smile
Chagass disease (how stupid you may become in exam
Totally forget flaria) where Chagas come from
Saved by bell 🔔
Got 18/26
2nd case
Totally straight forward
Bilateral limb swelling in HTN
I put differential
Then went to role out serious complication of HTN
There is decrease frequency of urination
With drug history on

Nefedipine for one year
Complain also from headache
Plan of management
Admit the pt
Switch nefedipine to other Med
Doing some test and scan to ur kidneys
Those were the answer of the concerns
Examiners
Q1. How to mange pt
Education, stop medications switch to other Med, elevation of the foot
Q2. What Med you will give pt
I said ACI
Why not diuretic
I said not recommend as pt having dependent odema + there no evidence of fluid over load
I got 24/26

Station 2
History
Middle age female newly diagnosed HTN
With persistent high reading
Approach with systemic manners
No symptoms suggestive of end organ damage
No symptoms of all secondary causes of HTN
Reached gynecology history
Pt was having irregular menses with prescribed OCP for 1 year
No other important history
(after I reached concern I remembered to ask biological family if the pt was adopted (APkD) as in DR.zain scenario)
Concerns
1. Do I need to take Med for life
Ans as your HTN probably due to Med there is a good chance it might be temporary
2.will it affect me having babies
Ans. High Blood pressure may serious with pregnancy multi desplinary team involving pregnancy specialist and your physician would keep a good eye over it
Plan of managemen
Stop the OCP , seek alternative with the help of ur pregnancy specialist
We will do some test and may be scan to ur kidneys to see the extend of ur disease
Examiners questions
Q.1 what is ur diagnosis and differential

Q.2 what is common-cause in this country if it is renal cause
I answered post streptococcus GN
I got 20/20

Delhi

1/24

****

Delhi Diet 1-2024

LCC 1: A 45 yrs old gentleman comes with backache. All the classical features of Ankylosing spondylitis. Ask series of questions on AS management.

LCC 2: A 55 years old man comes with arm pain and low grade fever for 3 days and Hypertension. Inside, Complications of fustula. Ask question about fistula and Management of all.
Respi: Acute exaggeration of Obs. Airway disease

Cardio: MVR with creps in lung base

Abdomen: Hepatospelnomegally and ascities and sign of CLD

Neuro: Peripheral sensory neuropathy

Comm 1: 24 hours holters done, suggestive AF. prior two episodes of TIA. Counsel about disease and anti coag. (no name mentioning about anti coag)

Commu 2: a 45 yrs lady with chest infection 3 months back, xray and CT done, discharged and asked for respiratory review. Somehow, mislaid level and miss flagging in respiratory MDT. Lost follow up. 2 weeks b4 son confirmed over telephone that about follow up. Mother comes and breaks nees and breaks this gap of communication.

*****_

Delhi

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*****
New Delhi 31st March

CVS : AR +\- AS

CNS: Peripheral Neuropathy

Abd: Splenomegaly

RS: COPD

CC1: Pulmonary embolism with DVT

CC2: Fitula with CKD with an infection in the fistula

Communication 1: Discuss about anticoagulation for AF in background of recent TIA

Communication 2: Discuss about treatment investigation and prognosis of PMR

*****
New delhi Day 4, 2nd carousel
Respi : Infective ex of COPD
Abdomen : Splenomegaly, Jaundice, Leukonychia
Neuro : PSMN
Cardio : AS with AR
Lcc 1 : Infected Fistula
Lcc 2 : DVT with Pul Embolism
Comm 1 : TIA with Af, options for Anticoagulants
Comm 2 : PMR with steroid counselling

****
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***
Delhi

Resp: COPD

Abdo: anemia+spleen in yound pt

Cardio: MVR

Neuro: Spastic paraplegia with dorsal column loss

Comm 1: aspirin side effect, pt thought allergy

Comm 2: dnacpr decision was taken when pt was in delirium discussing with husband, now pt fine and will be discharged. Talk to her regarding the DNacpr decision

Lcc 1: severe headache in a young female. Obese. No positive finding

Lcc 2: 70 yrs male.with dizziness and fall. Examiner er qstn sune mone hlo anemia sunte chai. Examination e anemic clo na..specifically black tarry stool jiggs korte hbe..

******

Delhi

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****

Delhi Day 3 3rd carousel

Cardio : As with Ar

neuro : PSMN

Respi : Copd with bronchiextasis

Abdomen : Splenomegaly with jaundice

Lcc 1 - RA With drug complication steroid and mtx

Lcc 2 - CTS due to Hypothyroidism

comm 1 - Cellulitis with MRSA

comm 2 - Advanced Parkinsons with multiple feeding options

Lcc :1.hair growth

2.confusion

Neuro :polio
Cvs : cabg with avs with as with af
Abdomen :renal transplant
Res : asthma
Communication :
Hep C
Mtx induced pneumonitis
****
Delhi second carousel today 30.4.24

Resp: obs airway ds with exacerbation
Cvs MR MS AF PHTN
Neuro: spastic paraplegia, sensory intact n severe ataxia: ms/ FA
Abd: some saying hepatospleenomegaly some hepatomegaly n cld features

Lcc ibd
Lcc mvr with infective endocarditis
Communication- amiodarone induced fibrosis. Pt daughter upset.
Comm_ pt with uncontrolled dm, now refusing insulin n driver. Talk wth him to convince

****

3/23

communication: COPD management, pt is on LABA + ICS, frequent exacerbation, now will be adding LAMA, still smokes (few cig).

Discuss the management plan

cc: sudden confusion in elderly patients, with 5 day h/o **fever** + SOB , known HTN, DM, heart **surgery** done 15 years before, and drinking **alcohol**.

O/E:
Midline sternotomy scar, lateral thoracotomy scar, hepatomegaly, temp: N, SaO2: N, BP: 100/60.

Chest: expiratory wheeze.

I mentioned all possible d/dx.

comm 2: MND, counselling about PEG, NIV (mentioned AD, LPA as well in the end)

cc2: left arm pain + fever in a px with Av Fistula
mentioned anticoagulant, colour doppler, RFT, IV antibiotics and admission (examiners seemed surprised! Don't know why)

*****_**
Delhi india diet 3

Clinical Consultation-
1.RA ILD and
2. peripheral neuropathy with charcot joint.

Resp- ILD
Cardio - MVR
Neuro - Hemiplegia, stroke
Abdomen- CLD with ascites

Communication -
1. Missed alendronate for a patient with osteoporosis and developed a fracture 5 days later.

2. Driver with stroke for advice regarding continuing his driving job.

♦♦♦♦
DELHI TODAY

Lcc 1:SS with SOB(Fibrosis was finding)

Lcc 2:
Acne r hair growth
Discussion on pcos metabolic syndrome cushing hypothyroid

Communication 1:
Pt admitted with UGI bleeding planned for OGEndoscopy.was on npo.But due to another emergency patient had to postpone. Pt wants self discharge.
Negotiate with it.

Communication 2:
Patient admitted in AMU with fever and disorientation 3days back. Treated for viral **encephalitis** with iv acyclovir. Urgent LP and MR scan pending.

BBN, Mx plan and Convince for LP

Respi:ILD
Neuro:Chorea

******
India today

Cc

Sob for 2 days
Inside ss with lung fibrosis
Ranauds
All skin manifestations
Sob for 6 months now inc for 2 days
Patient was on mtx for joint pain ..

Cc
Hand pain
And fever 38
Ckd patient with arm Swollen and there was fistula with aneurysm and swelling.

Communication
Failed colonoscopy due to inadequate bowel prep so procedure cancelled

Task why it was cancelled and counsel for alternative urgent CT

C.2
Patient smoker presented with hemoptysis and xray shows rt mass,ct confirmed lung carcinoma
Task. Tell the results of ct and further mgt.
****
MRCP PACES Diet 03/2022 New Delhi: Cases in Delhi Young Female with MVR Pulse regular no AF 6th cranial nerve palsy Bronchiectasis Ascites with splenomegaly with other signs of CLD like palmer erythems spider navi Station 2 young male with Diarrhoea Case of IBS...D/d of diarrhoea , Everything's fine having h/0 alcohol intake no positive drug, family history other co-morbidities Ask me regarding stool study specifically calprotectin test Station 4 Case RA with MTX induced Fibrosis Breaking bad News Plan to start steroid Station 5 Acromegaly Hypothyroid Delhi 3rd day,2nd carousal

DELHI SCENARIO

MRCP Paces

St 4: 40 years old lady had frequent visit to doctor due to multiple systoms. This time CT head,,, blood test done, all are normal.
Explain the lady about the report and further management.
It was a case of chronic fatigue syndrome.
Sarrogate was not well trained. From the history i got she is a housewife had to do all the house work, but she wants to do job. Family members disagree about this.
it was hard for me to understand the speaking of the british examiner. He asked a question 3 times i couldn't get what he was asking... :(
score:11/16
St5
BCC1: Out side 65 yrs old lady had fall this morning.
She was diabetic, hypertensive which are well controlled.on query she said feeling dizzy while standing from sitting or lying position.
From the drug chart i got Telmisartan 40mg, Hydrochloro thiazide tablet..
I ask the examiner want to check for postural drop. They said In lying 120/85, in standing 100/70 . i check pulse, precordium, carotid.
Ask for checking fundis, nerbous system.. Examiner said no need.
I counsel for to stop the 2 drug and add another drug for HTN... and counsel for not to stand suddenly from lying position.
Concern: Is it stroke, will it happen again.
Dx:Drug induced postural hypotension.
Q. What is ur dx
Q.how to investigate
Q.Mx
got 28/28
BCC2: Outside 60 years male with left arm pain and fever.
i was in a black hole seeing this complain. No DD from outside.
Inside i found a diabetic pt with nephropathy with AV fistula.
Concern: Whats wrong with him, how will u manage his dialysis
Dx: Thrombophlebitis of Left AV fistula tract with uncontrolled DM with complications(retinopathy, nephropathy, neuropathy)
Q. what is ur dx
Q.How to invastigate
Q.How to manage
got 28/28

SYNAPSE
Medical Academy

DELHI SCENARIO

MRCP Paces

St1
Respiratory: ILD with systemic scelorosis with Pulmonary HTN
Q: Tell us ur finding
Q. What is ur Dx
Q: How to invastigate
Q: Why do u want to do BAL in ILD.
Q: What is the spirometry finding.
Q.management
Got 20/20
Abdomen: Hepatosplenomegaly with clubbing
Q:Dx
Q:Ix
Q:Mx
got 20/20
St2: 35 years old male with left knee and right ankle pain.
Inside i got pt had history of loose motion 1 week back. Inflammatory arthritis.H/O conjunctivitis no urerhritis. Had a girlfriend with H/O physical contact long ago but with full protection.No h/o jaundice.
Family history of psoriasis. Only earning member of the family.
concern: is it psoriasis? How will i maintain my family if i cannot go for work?How will u treat. Do i need injection.
Dx:Reactive arthritis
Q: Tell the history briefly
Q: what are the D/D
Q: How to test and mx
Q: if this is crystal arthritis will will be microscopic finding
got 20/20
Alhumdulillah.
passed with 167/172...
Cases in Delhi
Young Female with MVR
Pulse regular no AF
6th cranial nerve palsy
Bronchiectasis
Ascites with splenomegaly with other signs of CLD like palmer erythems spider navi
Station 2 young male with Diarrhoea
Case of IBS...D/d of diarrhoea , Everything's fine having h/0 alcohol intake no positive drug, family history other co-morbidities
Ask me regarding stool study specifically calprotectin test
Station 4
Case RA with MTX induced Fibrosis
Breaking bad News
Plan to start steroid
Station 5
Acromegaly
Hypothyroid

SYNAPSE
Medical Academy

DELHI SCENARIO

MRCP Paces

As far as i remember:
1. CLD hepatospenomegaly
2. Unilateral basal crackles in lung
3. Chorea
4. Cvs: bujhi nai, possiblybinfective endocarditis, splinter haemorrhage
5. Cts, hypotgyroid + diabetic foot and diabetes
6. Ibs, concern of ca colon in counselling
7. History gbs possibly
carousel 1:
St 2:
38 yrs old male,
Ankle swelling, 3 weeks, joint pain small hand joints with morning jamming, SOB in the scanario but surrogate said no!!!, urine analysis protein 3 +, past H/O MI, treated with stenting, now medication : aspirin, bisoprolol, atorvastatin, OTC- ibuprofen for joint pain,
Father has MI, mother had arthrits,recent wt gain 2/3 kg
D/D : NSAID induced nephropathy, SLE with lupus nephritis, secondary GN
St :3-
Cardio : MS with AF with Pul HTN
Neuro: Rt sided hemiparesis with NG Tube, cannula, Pulse oxumeter (totally unstable pt, cant co- operate!)
St4: bteast cancer treated, now suspicious CXR, 6 weeks back, angry pt, why the doctor did nt tell her the reports and discuss further management plan
St:5
BCC-1 recurrent falls
DM, HTN
BCC2: left arm pain with fever
Dx- thrmbophlebitis of AV fistula
St1
Resp: COPD with bronchiectasis
Abd: hepatosplenomegaly with deep jaundice
Abdomen: HSM e Ascites e Jaundice
Respi: SSc e DPLD
Neuro: Motor Neuropathy (My Has No NG, Stable, So Different Pt Than Dr. mitu)
Cardio: I Said AR... All Flow Murmurs In Aortic Pulmonary Places (Have A Good Look for It),
3rd carousal today:
St 1: COPD(+-) Bronchiectasis
Renal transplant with tunneld venous catheter
St 2: SOB,h/o MI with PCI many years back, travel to germany 6 weeks back, orthopnea, pnd present

SYNAPSE
Medical Academy

DELHI SCENARIO

MRCP Paces

St2: 35 years old male with left knee and right ankle pain.
Inside i got pt had history of loose motion 1 week back. Inflammatory arthritis.H/O conjunctivitis no urerhritis. Had a girlfriend with H/O physical contact long ago but with full protection.No h/o jaundice.
Family history of psoriasis. Only earning member of the family.
concern: is it psoriasis? How will i maintain my family if i cannot go for work?How will u treat.
Do i need injection.
Dx:Reactive arthritis
Q: Tell the history briefly
Q: what are the D/D
Q: How to test and mx
Q: if this is crystal arthritis will will be microscopic finding
got 20/20
Alhumdulillah.
passed with 167/172...
st 2: Diabetic autonomic neuropathy. exclude APS.
st4: Malignant htn with CKD stage 5. RRT counceilling .
CArdio: IE with AR
Resp: ILD with Iatrogenic cushing
neuro: HSMN
Abdo: Jaundice with hepatomegaly
st 5: Warfarin induced GI bleed
St5: statin induced myopathy
S-5 : 1.Fall due to hypopituitarism with acromegaly
2.neck swelling with hypothyroidism.
Cardio: MVR
Gastro: CLD with hepatosplenomegaly with ascites
Resp: COPD
Neuro: 6 th nerve palsy
Station-2: Chronic diarrhoea
Station-4 : RA with MTX, now developed ILD
Task : Explain LFT finding, offered new treatment (Biological drug)
Delhi
3rd day,2nd carousal
Diet1, 2019

SYNAPSE
Medical Academy

DELHI SCENARIO

MRCP Paces

start with st3
st3
Neuro:
examine upper limb of this patient.
When inspection i saw abnormal movement of the limbs.
i quickly examine upper limb then ask for relevant.
Check gait, motor impersistence at eye, tongue, hand, grip.
Pt also had KF ring.
dx:Chorea with Wilson disease.
Q: what are ur finding.
Q.What r the causes of chorea
Q.where is the lesion
Q.What chemical imbalance are related with this.
Q:How to investigate.
Q.Management
got 20/20
Cardio
This young lady presented with SOB.Examine CVS.
She has a midline sternotomy scar with metalic click with S1... systolic murmur at apex... bibasal creps..
Dx:Metalic MVR with valve dysfunction with failure.
Q.Tell the finding
Q. How to investigate
Q.How to manage
Q. What advice u will give to this young lady.
I said advice for drug interaction with warferin and advice for pregnancy.
Q.How will u manage this pt during pregnancy.
Q. What drug interaction may occur with warfarin.
I said enzyme inducer and inhibition drug. then said can u tell me some example.
Q. What newer anticoagulant are present.
Q. Will u give newer oral anti coagulant to this pt.
i said no...
Q.Why? i said they r for non valvular case.
Bell rang.
got 20/20

SYNAPSE
Medical Academy

DELHI SCENARIO

MRCP Paces

dx:Chorea with Wilson disease.
Q: what are ur finding.
Q.What r the causes of chorea
Q.where is the lesion
Q.What chemical imbalance are related with this.
Q:How to investigate.
Q.Management
got 20/20
Cardio
This young lady presented with SOB.Examine CVS.
She has a midline sternotomy scar with metalic click with S1... systolic murmur at apex... bibasal creps..
Dx:Metalic MVR with valve dysfunction with failure.
Q.Tell the finding
Q. How to investigate
Q.How to manage
Q. What advice u will give to this young lady.
I said advice for drug interaction with warferin and advice for pregnancy.
Q.How will u manage this pt during pregnancy.
Q. What drug interaction may occur with warfarin.
I said enzyme inducer and inhibition drug. then said can u tell me some example.
Q. What newer anticoagulant are present.
Q. Will u give newer oral anti coagulant to this pt.
i said no...
Q.Why? i said they r for non valvular case.
Bell rang.
got 20/20
St 4: 40 years old lady had frequent visit to doctor due to multiple systoms. This time CT head,,, blood test done, all are normal.
Explain the lady about the report and further management.
It was a case of chronic fatigue syndrome.
Sarrogate was not well trained. From the history i got she is a housewife had to do all the house work, but she wants to do job. Family members disagree about this.
it was hard for me to understand the speaking of the british examiner. He asked a question 3 times i couldn't get what he was asking... :(
score:11/16

SYNAPSE
Medical Academy

DELHI SCENARIO

MRCP Paces

St5
BCC1: Out side 65 yrs old lady had fall this morning.
She was diabetic, hypertensive which are well controlled.on query she said feeling dizzy while standing from sitting or lying position.
From the drug chart i got Telmisartan 40mg, Hydrochloro thiazide tablet..
I ask the examiner want to check for postural drop. They said In lying 120/85, in standing 100/70 . i check pulse, precordium, carotid.
Ask for checking fundis, nerbous system.. Examiner said no need.
I counsel for to stop the 2 drug and add another drug for HTN... and counsel for not to stand suddenly from lying position.
Concern: Is it stroke, will it happen again.
Dx:Drug induced postural hypotension.
Q. What is ur dx
Q.how to investigate
Q.Mx
got 28/28
BCC2: Outside 60 years male with left arm pain and fever.
i was in a black hole seeing this complain. No DD from outside.
Inside i found a diabetic pt with nephropathy with AV fistula.
Concern: Whats wrong with him, how will u manage his dialysis
Dx: Thrombophlebitis of Left AV fistula tract with uncontrolled DM with complications(retinopathy, nephropathy, neuropathy)
Q. what is ur dx
Q.How to invastigate
Q.How to manage
got 28/28
St1
Respiratory: ILD with systemic scelorosis with Pulmonary HTN
Q: Tell us ur finding
Q. What is ur Dx
Q: How to invastigate
Q: Why do u want to do BAL in ILD.
Q: What is the spirometry finding.
Q.management
Got 20/20
Abdomen: Hepatosplenomegaly with clubbing
Q:Dx
Q:Ix
Q:Mx
got 20/20

SYNAPSE
Medical Academy

DELHI SCENARIO

MRCP Paces

MRCP PACES
Mishu_K-67
New Delhi:

Cases in Delhi
Young Female with MVR
Pulse regular no AF
6th cranial nerve palsy
Bronchiectasis
Ascites with splenomegaly with other signs of CLD like palmer erythems spider navi
Station 2 young male with Diarrhoea
Case of IBS...D/d of diarrhoea , Everything's fine having h/0 alcohol intake no positive drug, family history other co-morbidities
Ask me regarding stool study specifically calprotectin test

Station 4
Case RA with MTX induced Fibrosis
Breaking bad News
Plan to start steroid

Station 5
Acromegaly
Hypothyroid
Delhi
3rd day,2nd carousal
Diet1, 2019
start with st3
st3
Neuro:
examine upper limb of this patient.
When inspection i saw abnormal movement of the limbs.
i quickly examine upper limb then ask for relevant.
Check gait, motor impersistence at eye, tongue, hand, grip.
Pt also had KF ring

SYNAPSE
Medical Academy

DELHI SCENARIO

MRCP Paces

St 3: cardio: mvr with as
Neuro: bhai didnt find anyrhing abnormal except increaed tone, discussion about spastic paraparesis
St 4: nut allergy, chef,anaphylaxis
St 5: bcc1: psoriatic arthritis
Bcc2: iatrogenic cushing
St 2 type 1 DM patient with Ida, DD ?
St 5 liraglutide started in a patient with DM came with abdominal pain and vomiting
Station 4 AF counseling for apixaban
St 5 proximal myopathy in patient taking steroid
Neuro wasting with LMN type lower limb
Cardio mvr
Abdomen cld with jaundice with splenomegaly
Respi copd with bronchiectasis
Carousel3
Respi-?R-Fibrosis
Abd-HSM with Jaundice
2-Headache with differentials
CVS-MS with AF
CNS-Ataxia ?cerebellar
4-Firefighter with asthma
5-Ankylosing Spondylitis
CVS - bicuspid aortic valve
Rs - young guy with ild , they later changed to copd
Cns- aidp
Abdo - hepatosplenomegaly , tattoo
History- knee ankle pain , reiters syn
Communication- meningococcal septicaemia - counsel wife
Station 5 - acromegaly headacheAnd ankylosing spond
Carousal 3 last day:
Respi: ILD due to SSc
Abdo: HSM with jaundice
Cardio: AS with AR? With CABG scar
Neuro: Stroke (but wasting with ankle & planters were absent..I told Motor neuropathy..examiner said to look at the upper limb..there was left forearm flexed) it was tough because patient was not co-operative..he had knee pain severe..
History: recurrent chest infection (CF, primary hypogamma)
Counselling: angry patient missed ovarian cyst 3 months back in MRI
Station 5: Left av fistula pain (cellulitis)
Psoriatic arthritis

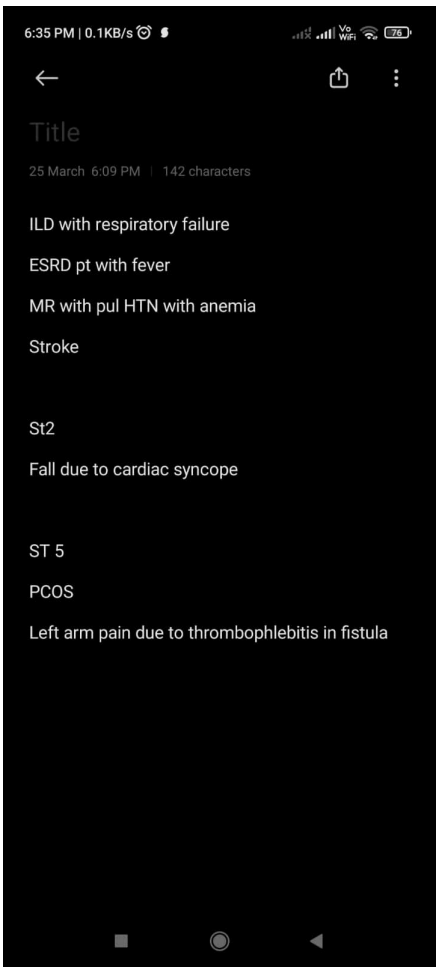
SYNAPSE
Medical Academy

DELHI SCENARIO

MRCP Paces

St 1: Respi: crackles+ rhonchi...DD given
Abdomen : jaundice + ascites+ splenomegaly+ peripheral oedema....DD given
St 2: knee and ankle pain, brother psoriasis, h/o loose motion before onset of illness. .. DD given
St 3: Cardio: AS+ AR+IE
Neuro: peripheral motor neuropathy
St 4 : husband meningococcal septicemia, talk with wife
St 5: bcc1, sudden headache...inside acromegaly+ pituitary apiplexy
Bcc2: backache for 6 months, AS and SpA
S-5 : 1.Fall due to hypopituitarism with acromegaly
2.neck swelling with hypothyroidism.
Cardio: MVR
Gastro: CLD with hepatosplenomegaly with ascites
Resp: COPD
Neuro: 6 th nerve palsy
Station-2: Chronic diarrhoea
Station-4 : RA with MTX, now developed ILD
Task : Explain LFT finding, offered new treatment (Biological drug)
chorea
mitral valve replacement with failure
hepatosplenomegaly- CLD
ILD with SS with Pul HTN
st4:Chronic fatigue syndrome
st2: reactive arthritis
st5: Postural hypotension & fall,
Thrombophlebitis of AV shunt in CKD Pt
In Cardio There is A DVR Case...Very Obese...
Cardiology: Isolated AR with H/0 fever.... IE
Respiratory : ILD with Iatrogenic Cushing syndrome
Abdomen: Jaundice with isolated hepatomegaly
Neuro: HSMN /CMTD
st 5: Warfarin induced P/R bleeding with AF
St 5: Statin induced myopathy, d/d diabetic amyotrophy.
St 2: DM autonomic neuropathy with recurrent hypoglycaemia, Prolong diarhhoea
St4: Angry pt with RFT deterioration with RRT counselling with h/o untreated HTN beforehand
But if you go close to that patient you can hear click...
with unaided ear
ILD e iatrogenic cushing
Acute viral hepatitis
DVR
PN
St 5: Graves , Acromegaly
1. CABG e AS (male patient, very long and curved graft harvesting scar)
2. CABG e permanent pacemaker e tissue valve replacement (shunte kichhuta mechanical AVR er moto chhilo)

SYNAPSE
Medical Academy



St 4 epilepsy patient non compliant with medication

******
Diet1, 2019
Delhi 3rd day,2nd carousel, Diet 1, 2019 start with st3 st3

Neuro: examine the upper limb of this patient.

When I checked I saw abnormal movement of the limbs. I quickly examine the upper limb then ask for something relevant.

Check gait, motor impersistence at eye, tongue, hand, grip.
Pt also had a KF ring.

dx:Chorea with Wilson disease.

Q: What are your findings?.
Q.What are the causes of chorea
Q.where is the lesion
Q.What chemical imbalance is related to this.
Q:How to investigate.
Q.Management

got 20/20

Cardio: This young lady presented with SOB.Examine CVS.

She has a midline sternotomy scar with metallic click with S1... systolic murmur at apex... bi basal crepts..

Dx:Metallic MVR with valve dysfunction with failure.

Q.Tell the finding
Q. How to investigate
Q.How to manage
Q. What advice u will give to this young lady. I said advice for drug interaction with warfarin and advice for pregnancy.
Q.How will u manage this pt during pregnancy.
Q. What drug interaction may occur with warfarin. I said enzyme inducer and inhibitor drugs.
Q.then said can you tell me some examples.
Q. What newer anticoagulants are present.

Q. Will you give newer oral anticoagulants to this pt.I said no...

Q.Why? i said they are for non valvular cases.

Bell rang. got 20/20

St 4: 40 years old lady had frequent visits to the doctor due to multiple symptoms. This time CT head,,, blood test done, all are normal. Explain the lady about the report and further management. It was a case of chronic fatigue syndrome.

Surrogate was not well trained. From the history I got she is a housewife who has to do all the housework, but she wants to do a job. Family members disagree about this.

It was hard for me to understand the speech of the British examiner. He asked a question 3 times i couldn't get what he was asking... :(score:11/16)

St5:
BCC1: Outside- A 65 yrs old lady had fallen this morning. She was diabetic, hypertensive which are well controlled.on query she said feeling dizzy while standing from sitting or lying position. From the drug chart I got Telmisartan 40mg, Hydrochlorothiazide tablet..

I ask the examiner, I want to check for a postural drop. They said In lying 120/85, in standing 100/70 . i check pulse, precordium, carotid. Ask for checking fundus, nervous system.. Examiner said no need.

I counsel for to stop the 2 drug and add another drug for HTN... and counsel for not to stand suddenly from a lying position.

Concern: Is it a stroke? Will it happen again?.

Dx:Drug induced postural hypotension.
Q. What is ur dx?
Q.how to investigate?
Q.Mx?

got 28/28

BCC2: Outside 60 years male with left arm pain and fever. i was in a black hole seeing this complain. No DD from outside. Inside i found a diabetic pt with nephropathy with AV fistula.

Concern: Whats wrong with him? , how will u manage his dialysis?

Dx: Thrombophlebitis of Left AV fistula tract with uncontrolled DM with complications(retinopathy, nephropathy, neuropathy)
Q. what is ur dx
Q.How to investigate
Q.How to manage

got 28/28

St1 Respiratory: ILD with systemic sclerosis with Pulmonary HTN

Q: Tell us your finding
Q. What is ur Dx
Q: How to investigate
Q: Why do you want to do BAL in ILD?
Q: What is spirometry finding? Q.management?
Got 20/20

Abdomen: Hepatosplenomegaly with clubbing
Q:Dx
Q:Ix
Q:Mx
got 20/20

St2: 35 years old male with left knee and right ankle pain.

Inside: I got a patient that had a history of loose motion 1 week back. Inflammatory arthritis.H/O conjunctivitis, no urethritis. Had a girlfriend with H/O physical contact long ago but with full protection.No h/o jaundice. Family history of psoriasis. Only earning members of the family.

Concern:
Is it psoriasis?
How will I maintain my family if I cannot go to work?
How will you treat?. Do I need an injection?.

Dx:Reactive arthritis
Q: Tell the history briefly
Q: what are the D/D
Q: How to test and mx
Q: If this is crystal arthritis what will be a microscopic finding?
got 20/20
Alhumdulillah. passed with 167/172...

st 2: Diabetic autonomic neuropathy. exclude APS.

st4: Malignant HTN with CKD stage 5. RRT counselling .

Cardio: IE with AR
Resp: ILD with Iatrogenic cushing
Neuro: HSMN
Abdo: Jaundice with hepatomegaly

st 5: Warfarin induced GI bleed
St5: statin induced myopathy

S-5 : 1.Fall due to hypopituitarism with acromegaly
2.neck swelling with hypothyroidism.

Cardio: MVR
Gastro: CLD with hepatosplenomegaly with ascites
Resp: COPD
Neuro: 6 th nerve palsy

Station-2: Chronic diarrhoea

Station-4 : RA with MTX, now developed ILD
Task : Explain LFT finding, offered new treatment (Biological drug).

Cases in Delhi :
A Young Female with MVR Pulse regular no AF
6th cranial nerve palsy
Bronchiectasis
Ascites with splenomegaly with other signs of CLD like palmar erythema, spider naevi

Station 2 young male with Diarrhoea Case of IBS...D/d of diarrhoea , Everything's fine having h/0 alcohol intake no positive drug, family history other comorbidities.

Asked me regarding stool study specifically calprotectin test

Station 4 Case RA with MTX induced Fibrosis Breaking bad News Plan to start steroid

Station 5 Acromegaly Hypothyroid As far as i remember:

1. CLD hepatosplenomegaly
2. Unilateral basal crackles in lung
3. Chorea
4. Cvs: bujhi nai, possibly infective endocarditis, splinter haemorrhage
5. Cts, hypothyroid + diabetic foot and diabetes
6. Ibs, concern of ca colon in counselling 7. History gbs possibly

carousel 1:
St 2: 38 yrs old male, Ankle swelling, 3 weeks, joint pain, small hand joints with morning jamming, SOB in the scenario but the surrogate said no!!!, urinalysis protein 3 +, past H/O MI, treated with stenting, now medication : aspirin, bisoprolol, atorvastatin, OTC- ibuprofen for joint pain, Father has MI, mother had arthritis,recent wt gain 2/3 kg D/D : NSAID induced nephropathy, SLE with lupus nephritis, secondary GN

St :3- Cardio : MS with AF with Pul HTN
Neuro: Rt sided hemiparesis with NG Tube, cannula, Pulse oximeter (totally unstable pt, can't co- operate!)

St4: breast cancer treated, now suspicious CXR, 6 weeks back, angry pt, why the doctor didn't tell her the reports and discuss further management plan

St:5
BCC-1: recurrent falls DM, HTN
BCC2: left arm pain with fever Dx- thrombophlebitis of AV fistula

St1 Resp: COPD with bronchiectasis Abd: hepatosplenomegaly with deep jaundice

Abdomen: HSM e Ascites e Jaundice Respi: SSc e DPLD
Neuro: Motor Neuropathy (My Has No NG, Stable, So Different Pt Than Dr. mitu)

Cardio: I Said AR... All Flow Murmurs In Aortic Pulmonary Places (Have A Good Look for It),

3rd carousel today:
St 1: COPD(+-) Bronchiectasis
Renal transplant with tunneld venous catheter

St 2: SOB,h/o MI with PCI many years back, travel to germany 6 weeks back, orthopnea, pnd present

St 3: cardio: mvr with AS
Neuro: bhai didnt find anyrhing abnormal except increaed tone, discussion about spastic paraparesis

St 4: nut allergy, chef,anaphylaxis

St 5:
bcc1: psoriatic arthritis
Bcc2: iatrogenic cushing

St 2 type 1 DM patient with IDA, DD ?

St 5 liraglutide started in a patient with DM came with abdominal pain and vomiting

Station 4 AF counselling for apixaban

St 5 proximal myopathy in patients taking steroid

Neuro wasting with LMN type lower limb
Cardio MVR
Abdomen CLD with jaundice with splenomegaly
Respiratory COPD with bronchiectasis

Carousel 3
Respi-?R-Fibrosis
Abdomen- HSM with Jaundice

2-Headache with differentials

CVS-MS with AF
CNS-Ataxia ?cerebellar

4-Firefighter with asthma

5-Ankylosing Spondylitis

CVS - bicuspid aortic valve
Rs - young guy with ild , they later changed to copd
Cns- aidp
Abdo - hepatosplenomegaly , tattoo

History- knee ankle pain , reiters syn

Communication- meningococcal septicaemia - counsel wife

Station 5 - acromegaly headache- And ankylosing spond

Carousel 3 last day:
Respi: ILD due to SSc
Abdo: HSM with jaundice
Cardio: AS with AR? With CABG scar

Neuro: Stroke (but wasting with ankle & planters were absent..I told Motor neuropathy..examiner said to look at the upper limb..there was left forearm flexed) it was tough because the patient was not cooperative..he had knee pain severe..

History: recurrent chest infection (CF, primary hypogamma)

Counselling: angry patient missed ovarian cyst 3 months back in MRI

Station 5: Left av fistula pain (cellulitis) Psoriatic arthritis

St 1: Respi: crackles + rhonchi...DD given Abdomen : jaundice + ascites + splenomegaly + peripheral oedema....DD given

St 2: knee and ankle pain, brother psoriasis, h/o loose motion before onset of illness. .. DD given

St 3: Cardio: AS+ AR+IE
Neuro: peripheral motor neuropathy

St 4 : husband meningococcal septicemia, talk with wife

St 5: bcc1, sudden headache...inside acromegaly + pituitary apoplexy

Bcc2: backache for 6 months, AS and SpA

S-5 :
1.Fall due to hypopituitarism with acromegaly
2.neck swelling with hypothyroidism.

Cardio: MVR
Gastro: CLD with hepatosplenomegaly with ascites
Resp: COPD
Neuro: 6 th nerve palsy

Station-2: Chronic diarrhoea

Station-4 : RA with MTX, now developed ILD Task : Explain LFT finding, offered new treatment (Biological drug)

chorea
mitral valve replacement with failure
hepatosplenomegaly- CLD
ILD with SS with Pul HTN

st4:Chronic fatigue syndrome

st2: reactive arthritis

st5: Postural hypotension & fall, Thrombophlebitis of AV shunt in CKD Pt In

Cardio There is A DVR Case...Very Obese...

Cardiology: Isolated AR with H/0 fever.... IE
Respiratory : ILD with Iatrogenic Cushing syndrome
Abdomen: Jaundice with isolated hepatomegaly
Neuro: HSMN /CMTD

st 5: Warfarin induced P/R bleeding with AF
St 5: Statin induced myopathy, d/d diabetic amyotrophy.

St 2: DM autonomic neuropathy with recurrent hypoglycemia, Prolonged diarrhoea

St4: Angry pt with RFT deterioration with RRT counselling with h/o untreated HTN beforehand

But if you go close to that patient you can hear a click... with an unaided ear. DVR

ILD e iatrogenic cushing
Acute viral hepatitis
PN

St 5: Graves , Acromegaly

1. CABG e AS (male patient, very long and curved graft harvesting scar)

2. CABG e permanent pacemaker e tissue valve replacement (shunte kichhuta mechanical AVR er moto chhilo)

******
2018/1 New Delhi
(9.02.2018)

station 5
1.40 yr old lady with pain abdomen and vomiting since 4 days...known diabetic on insulin..sugar was not under desired levels.. discussion was around DKA and acute cholecystitis

2..40 year old lady with diarrhoea and vomiting ..7 days had outside food.. discussion about food poisoning and admission

Stn 1.abd.abd massive splenomegaly..
discussion about myeloproliferative disorders and Rx

Respi..COPD

Stn 2..40 year old male with collapse..was
known DM with all pathies/htn/af/ihd

Stn 3...cardio..midline sternotomy in old lady pacemaker in situ.. discussion about MVR, metallic

Neuro.cranial nerve exam...young lady around 20 years.. findings..7.9.10...involved .. discussion
about icsol..

Stn 4..talk to son about mother who had
delirium following uti and developed black
ulcers on foot (never heard in India about such term) presumed it to be pressure ulcer and explained ..task explain and clear concerns.

****
Delhi
Station 1 : ?right effusion ? ILD.. . The effusion findings were not very good.
Gave DD of fluid related crackles as well. .

GI was CLD with ascites with elevated jvp

Station 2: history regarding fatigue, fever,
cough since 3 weeks in 50 year old male.
Station 3: left hemiparesis with facial palsy
CVS was mvr with AS

Station 4: drug error. Asthmatic patient with HF given bisoprolol.

Station 5.
- acute onset confusion in elderly
-meningitis

*****
New Delhi
station 1
Resp: pleural effusion unilateral with av fistula
Discussion was about causes of unilateral
effusion in esrd patient...

Abdomen: gross ascites but no other signs of cld... no organs palpable
I said could be tb peritonitis etc
But examiner asked all about cld maybe I
missed something

Station 2
Lady with breast cancer progressing on multiple

lines now wants to be admitted because family
can't take care of her...
I got a lil stumped in this because this is not the
usual history taking...
in history got points that she is still in pain,
clinically depressed , symptoms not controlled ...
asked about pain meds she was on morphine
ibuprofen paracetamol etc
I said will admit for pain control and to find out
why having pain...
Bt examiners were still not happy...
They said you should ask individual side effects
of each med... like for morphine constipation,
for paracetamol about jaundice whether she
knows max limits and is she exceeding it etc
Screwed up this one

Cvs: young lady with bivalvular replacement
Asked why... I said rheumatic
Then he asked me why do you think she had
metallic and not bio valve
Again was stumped for a while gave pros and
cons for both types ... and said she may need
another surgery later on in life... discussion
about anti coag which I answered
Neuro: guy with muscle wasting , high arched
foot , intact sensations
Was thinking hsmn but sensations intact... gave
it as differential
Examiner asked can it be polio, then realized
maybe it was polio

St 4
Wife went to work and collapsed ... has signs of meningococcal meningitis and needs icu
First part was about patient updates and that
she is sick may die...
I said we hope that she will recover because she
was brought within 4 hours started antibiotics
on time etc
second part about contact tracing- public health
issue
Can do it without his consent also (this was the
ethical issue)
In discussion examiner said you didn't say that
disease has high mortality
Bcc 1
Long standing asthma patient on oral steroid
cane with sudden onset back pain

D/d osteoporosis fracture
She asked me what apart from these can come
suddenly with back pain i Said ovarian torsion
bt overall I did well they were happy i did slr

Bcc2 young man cane with blood in stool... on and constipation for 8 months.
Father has polyps which were benign

Gave d/d of colorectal ca, polyps, piles, fissure

Discussion was about screening guidelines

**
3rd carousel (9.02.2018)
St1: Abd Huge ascites with Mark for recent
paracentesis and scar in upper abd of recent shingles. Dd CLD/Malignancy

Resp Fever with cough. Dd Pneumonia, TB

ST 2: 30Male h/o unilateral headache for 1 yr
which has increased in last 2 months. During
last 2 month he is having cocodamol qds.
Concern- what is the cause. Can it be tumour.
Diag Analgesic abuse headache in the
background of migraine.

St3: Neuro Chorea.

Cardio - DVR with infective end. Viva on IE

ST4: M45yrs having at loss enlarged liver,
Supraclav LN. CT and FNAC done. CT
suggestive of upper lobe mass with liver mets.
FNAC report is missing. Your friend who did the
FNAC is on leave. Boss is out of station. He
instructed u to talk to pt. And repeat FNAC. Very
angry surrogate. Hardly allowing to speak.
St5: BCC1- Sudden SOB for 4 hrs. On exam DVT
with PE.- Surrogate.

BCC2 - Maroon colour stool with new
constipation for 8 months. Tenderness in LIF.
Father had polyps. Had dizziness and tachy.
Was on antiplatelets- Surrogate
1st carousel.(10.02.2018)
st 2.A 50yrs old man H/o Evening rise of
fever,Cough,SoB for last 2weeks. Haemoptysis
for 7days,Lethargy &weight loss for 3 months.

T2DM on Glargine 10 units. visited Kenya 6 months back.Smoker 10 cigarettes a day.D/DTB,Ca lung,Lymphoma,HIV

St3-DVR+IC drain in right side.sick patient.Pneumonia with effusion.very sick patients.Neuro -Upper limb-CVA. on inspection UMN facial palsy.

St 4 long scenario.53 years old patient Asthma plus ex smoker this time admitted with SOB.Revealed Heart failure.Improved with Diuretics &ACE inhibitor.Fit to discharge tomorrow. But one of your junior prescrbed Bisoprolol 5.Pharmacists warned nurse.that it is contradicted in Asthma.But patient heard it.Talk to patient

Questions -Ethical issue.Surrogate told about negligence. I apologised & mentioned that it is error. He is going to complain. Introduced to PALS.

BCC1-Elderly man c/o Confusion &fall for 7days.Known Hypertensive. Taking Thiazide .Hyponatremia

BCC2- Middle aged man having fever ,headache ,vomiting for last 5 days.

Inside different story. Known epilepsy taking Levetiracetam, Alcoholic. Treated as a case of viral menigitis.Discharged &again same c/o headache, vomiting, seizure.Now in emergency. on examination -only neck rigidly. D/D-Bacterial menigitis,TBM,Cerebral venous sinus thrombosis

St1-CKD with AV fistula in left hand with Right sided pleural effusion. CLD ascites with Midline sternotomy scar plus ?Portacaval shunt

Hyderabad

1/24

******

Hyderabad 3rd day

Carousel 3:

1. Respi: Unilateral bronchiectasis
2. Abdomen: Renal transplant
3. Cardio: DVR
4. neurology: Hemiparesis (stroke)
5. Lcc-

A. DM,HTN patient comes to you with vision loss (TIA)
B. Abdominal pain (Pancreatitis- risk factors Alcohol, hypertriglyceridemia)

6. Communication - terminal Patient wants discharge (patient refused to take any treatment) , ADPKD

*****

Hi dr,

Mine was:
Abdo: splenomegaly
Respi : unilateral bronchiectasis + wheeze
Cvs: MVR
Neuro: Spastic paraplegia
Lcc 1 : stroke
Lcc 2 : bloody diarrhea after eating streetfood but has hx of recurrent bloody diarrhea (dd IBD dd infectious diarrhea)
Comm 1 : MS
Comm 2 : suicide gliclazide

****

St 5
LCC
Prom: SOB, Weight loss
History: Prosthetic AVR, OA, fever
Drenching night sweat
Exam: lymph node, anaemia, abdomen tender
DD: lymphoma, disseminated TB, colorectal cancer, IE

St 1
Comm: T2 DM, antibodies negative, no need insulin, taxi driver

Respi: COPD

St 2:
LCC

collapse several episodes, last episode LOC
seizure due to alcohol overdose

St 3:
Cardio:
AVR, prosthetic valve

Neuro:
Upper limbs, clumsiness
PD

St 4:
Comm: Hickman line

Abdomen: huge splenomegaly
CML, ch malaria, ch kala azar, CLD with portal HTN (as i found muscle wasting, leukonychia, scanty hair)

******
Hyderabad 1st carousel

abdomen - splenomegaly with anaemia
Cardio - AR
Respi- acute ex of obstructive airway disease
Neuro - spastic paraparesis without sensory

LCC 1: bloody diarrhoea (dummy)
LCc 2 : Hemiparesis with umn type 7th CN palsy

Comm 1 : bbn of multiple sclerosis
Comm 2 : Sulfonylurea overdose

******
Hyderabad 3rd carousel
Abd - Jaundice with hepatomegaly
Cardio - Dual Valve replacement
Respi - upper lobe fibrosis
Neuro- hemiparesis with hemisensory loss
LCC 1 - Aki on CKD (h/o taking nsaid)
LCC 2 - Warfarin induced anaemia in Mitral valve replacement pt
Comm 1 : Bbn of ADPKD with genetic and screening counselling
Comm 2 : Counselling for IBS

*****_
Hyderabad 2nd day
Carousel 3:
1.respi:right upperlobe fibrosis, pt will only be in sitting position,can not give any cough

2.abdomen:anaemia,spleenomegaly,low hair distribution -lymphoproli,hereditery haemolytic ,CLd with portal htn,non chirrhotic poral htn-crossing was about non chirrotic portal htn
3.cardio:young age only sternotomy scar,no click,murmur,told dd,crossing was about congenital repair
4.neurology:rignt upper flaccid monoperesis with sensory loss,wasting: dd
5LCC: pt was admitted with abdomen pain+swelling,treated accordingly. Now came to followup. Dd: SBP,acute pancreatitis,chronic hepatitis
6.LCC: post CABG upper GI malaena
7.communication: parkinsons missed dose, asthma steroid inhaler counselling

******
Hyderabad diet 1/2024
CVS - MVR plus AVR
Abdomen- CLD
Respiratory- Fibrosis right upper lobe
CNs- hemiplegia
Communication 1 - explaining diagnosis IBS
Communication 2- breaking bad news ADPKD
Long case 1- anemia in chronic renal failure
Long case 2- warfarin induced anemia in Post MVR
****

Hyderabad today. From my friend

Consult 1 coeliac ds, u/l psoriasis, SM, H/T on MTx, aspirin
Consult 2 Unresolved pneumonia Tuberculosis,bronchiectasis
Com1: thyrotoxicosis explain ds, drugs- cazole, propranolol
com 2: epilepsy control on lamotrigine want to get pregnant, related to drug or not
CVS AVR
Abd COl with ascites
Resp bronchiectasis
CNS ??hemiplegia

3/23

Hyderabad today♦♦♦
DIET-3,2023
4th November

LCC1. Uncontrolled HTN and blood glucose previous surgery for pituitary tumour

LCC 2. Abdominal pain , diagnosed case of CLD

Communication:

1. BBN with LP - Viral encephalitis

2. BBN with error- AVN

Cardio - MVR e marfans
Respiratory inf exacerbation of COPD
Neuro - Spastic para paresis with dorsal collumbloss
Abdomen - Splenomegaly

2nd round, Different cases were ⏩Hyderabad

1. AVR functioning well
2. Old Lobectomy for COPD/Bronchiectasis
3. Lt Hemiplegic stroke
****
🟣 *EXAM Cases NICELY SHARED From*
Hyderabad Candidates
🟢1. Communication: Fever with confusion x 3 days; suspected viral encephalitis; Patient disoriented; convince his wife for LP (Wife said why unnecessary poke needle, he'll be in pain; instead do some simple tests)

2. Abdomen: Massive firm smooth surface Splenomegaly in a young man. Also had some vitiligo lesions (unrelated)
Viva on causes, investigations, & management

3. Consultation: middle age man with pain abdo, h/o Hep B & 6 unit/wk alcohol had Hepatomegaly with ascites. Had tremors of hand, spider nevi, gynaecomastia, pedal edema.
Concern: Can i undergo Liver transplant, Why pain, management

4. Consultation: Middle age man, optd Pituitary Tx., had features of Acromegaly. Now has uncontrolled DM & HTN. No positive findings on exam except Acromegaly features (no field defect, prox. Myopathy, CVS: NAD, fundoscopy normal)
DD: Recurrence of Adenoma Pituitary

5. Communication: 26 yr old man with IBD, can't come for regular follow up due to work. All treatments failed due to poor compliance, so they were given steroids & now develop AVN.

Concerns: Why wasn't it informed to me? Sole earning member of family. What is your further plan?

6. AVR functioning well; had breathlessness in instructions.
Viva: Why breathlessness, Indications of AVR

7. Lobectomy: ?COPD/Bronchiectasis; Scattered wheeze & coarse crackles.
Viva: Investigation & management

8: Lt hemiplegic stroke: Instruction: exam CNS
Could do LL, partial UL & face
Tone: Normal, Power: Reduced, Reflexes: Brisk, Sensation: Normal, Had circumduction gait

Really appreciated

******
Hyderabad today
Day 2, carousel 2
♦♦♦♦♦♦♦♦
🟣Station - 1: Lumbar puncture explaining to wife for viral encephalitis.

Respiratory : lobectomy. done for what causes?, I said Malignancy, COPD.

🟣Station - 2: acromegaly, post pituitary surgery, now uncontrolled diabetes and hypertension

🟣Station - 3: Hemiparesis, AVR

🟣Station - 4: IBD, took steroids, landed in AVN femur head and hip transplantation done. Pt angry for not telling him the adverse effect;

Abdomen : Splenomegaly

🟣Station - 5: Cirrhosis of liver, hepatitis-B and alcoholic now presented with pain abdomen. After all was done examiner was expecting pancreatitis for pain abdomen, which I could utter at the last second

****
Hyderabad today diet 3
🎯✍️
Hi madam
We got following cases

Station - 1: Lumbar puncture explaining to wife for viral encephalitis, lobectomy done for ?cause, I said Malignancy, COPD

Station - 2: acromegaly, post pituitary surgery, now uncontrolled diabetes and hypertension

Station - 3: Hemiparesis, AVR

Station - 4: IBD, took steroids, landed in AVN femur head and hip transplantation done. Pt angry for not telling him the adverse effect; Splenomegaly

Station - 5: Cirrhosis of liver, hepatitis-B and alcoholic . now presented with pain abdomen. After all was done examiner was expecting pancreatitis for pain abdomen, which I could utter at the last second 🙏

_*****
Hyderabad today 🟩🟩

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CVS AVR
Abd COl with ascites
Resp bronchiectasis
CNS 💠hemiplegia

****
HYDERABAD 3rd Day Recall♦♦♦
🟢Consultation 1
CVA with episode of seizure.
🟢Consultation 2
Post TB bronchiectasis
🟢CVS
AVR
🟢RS
lung fibrosis
🟢Abdomen
alcoholic liver disease
🟢CNS parkinsons

******
[08/03, 6:16 am] +971 58 591 6526: Hyderabad day 1
1st carousel

Bcc 1: varices
Bcc 2: 2 PUD rheu hand

Cardio: clubbing,left sternal area murmur, pt has av fistula

Neuro: Upper motor in lower limb

4: IE wants to go home

2: palpi post partum

Respi: Effusion

Abdomen: Renal transplant
[08/03, 6:16 am] +971 58 591 6526: Hyderabad last round (9.7.2023)

St 1 Resp (breathlessness)
Left lung base collapsed
Right lung base fibrosis
Q: why trachea mid
A: because of Lower lobe
Causes, Inv, Mx.

St 1 Abdo (abdominal discomfort)
Patient has some left eye pathology
Sucken eye with non functioning.
Small small multiple scar (+) in the chest and abdomen. (Confused)
Answered for Moderate spleenomegaly
DDx, Inv

St 2
23 lady, Dizziness and palpitation 4 weeks, mostly on exertion, No LOC
Dry cough and fatigue association.
Not severe covid infection and after that symptoms developed.
Everything no for systematic review.
Father heart attack.
Swimming coach.
Asthma on inhaler prn.
Migraine on paracetamol prn.
DDx
Post covid fatigue
Arrhythmia
Anaemia
Postural hypotension (examinor)
Heart problem?
How should I do?
How you treat me?

St 3 CVS (breathlessness)
Although patient has cyanosis and clubbing, murmur audible both systolic and diastolic mainly LSE and pulmonary area. Pul HTN (+)
Answer for eisenmenger $
Multivalvular may be DDx
Because of older age and forgot to mention TOF (no scars)

St 3 CNS
Left upper limb LMN lesion.
Proximal wasting> distal.
Power 2/5, can't perform anything.
Patient exhausted.
Not allowed to examine LL
? Left Horner (no Q and no A)
Anterior horn cell or brachial plexus pathology
St 4

Young male, physical training teacher, arrange for marriage 3 months.
Weakness, right upper limb with cerebellar lesions.
MS likely lesion in MRI.
Blurred vision in teen age 17?
Uncle MS terminal stage.
Breed winner
What should I do?
Should I tell to her?
Should I tell to boss?
Why you said up to him to tell his lady?
Out of your range?

St 5 BCC 1
54 male, AWMI PCI 4 days, plan to discharge, collapsed, vital normal
DAPT+BB+ACEI
Inside:
Normal person with radial band
Postural drop (+)
Luckily I got GI haemorrhage history
Inv , Mx

St 5 BCC2
56 lady, Difficult walking, vital normal
Inside:
Cushing feature
Right hip pain
Can walk with abnormal gait
SLR pain (+)
Could not find out causes
8 drugs list, I can't see (stressful)
I saw Prednisone, she has rheumatology disorder(not mention)
On HD 6 months
AVF on right hand, failed scar also on left. ? Renal transplant (failed graft, forgot again for that)
Explained for this problem, she said already Dx AVN since 6 months
Precipitated cause?
Examiner try to ask questions but time out.
[08/03, 6:16 am] +971 58 591 6526: Hydrabard day3
St 3 Cardio mitral valve replacement
Neuro Ulnar and radial nerve palsy

St 4 Explain UC and further management

ST5 BCC1 Type 1 DM Admitted with DKA now discharge plan, Hypoglycemic awareness
BCC 2 SOB, Chest tightness with UL crohn' disease

St 1 Respi Lt lower lobectomy with UL bronchiectasis
Abdomen Massive splenomegaly

St 2 SOB, worsening wheezing,cough with UL asthma
[08/03, 6:16 am] +971 58 591 6526: BCC1 Real scenario is
T1 DM admitted for DKA,now plan for discharge but sister worried about recurrent episode of hypoglycemia...inside surrogate tell one episode of hypo...pt cocaine and amphetamine abuser..
Compliance with medication
BCC2 CD with colostomy bad SOB for three months...only on exertion
No positive finding
[08/03, 6:16 am] +971 58 591 6526: Hyderabad last round (9.7.2023)

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CVS AVR
Abd COl with ascites
Resp bronchiectasis
CNS 💠hemiplegia
[08/03, 6:16 am] +971 58 591 6526: Hydrabad DIET-3,2023
4th November
LCC1. Uncontrolled HTN and blood glucose previous surgery for pituitary tumour
LCC 2. Abdominal pain , diagnosed case of CLD
Communication 1. BBN with LP - Viral encephalitis
2. BBN with error- AVN
Cardio - MVR e marfans
Respi- inf exacerbation of COOD
Neuro - Spastic para paresis with dorsal collumbloss
Abd - Spleenomegally
[08/03, 6:16 am] +971 58 591 6526: 🟣 *2nd round, Different cases were* ⏩Hydrabad

1. AVR functioning well
2. Old Lobectomy for COPD/Brochectasis
3. Lt Hemiplegic stroke
*****

2/23
S-2 BA/occupational

4- UC

Abdomen- splenomegaly
Res- COPD
CVS- VSD
Neu- Stroke

Bcc1 SOB in crohns
Bcc2 Erratic Blood sugar

All cases r confusing, these was my D/Ds

Diet 1/ 2023

Hyderabad, 1st carousel,my station :

st-1 :
abdomen- renal transplant
respi- pneumonectomy due to ILD

st-2 :
peripheral neuropathy (chronic lead poisoning, HIV,Metronidazole)

St-3 :

cardio- DVR, at first i said MVR, gave hints then i said DVR

neuro -stroke hemiplegia, facial nerve palsy

St-4 :
lung cancer with cerebellar mets, bronchoscopic biopsy.

St- 5 :

bcc2: 30 yrs old lady having dizziness for 1 week: diabetic complications / BPPV

(i can't say it,asked many questions but no physical finding, may be a dummy case).

bcc 1: 57 yrs man having abdominal pain: Cirrhosis of liver with portal vein thrombosis

HYDERABAD India 3 rd Session

STATION 5

1.39 year lady with arm weakness

2. 60 yr male with recent AKI. now worsening SOB

Statio1

RS

left pleural effusion for DD

ABDOMEN : CLD with jaundice

station 2

Type I diabetic erratic lifestyle recurrent DKA admission

Station 3

CVS : Bicuspid aortic valve with AS

NEURO : 3 RD and 4 th cranial nerve palsy

station 4

Post MI

post PTCA

no tiredness and bruisability

hyderabad today's 1st carousel

st-1
respi- b/l bronchiectasis
abdomen- splenomegaly

st-2:
Sheehans

st-3
neuro- claw hand with scar
cardio - AR

St-4
mtx with trimethoprim

St- 5

Disseminated TB with travel history and contact positive

Pacemaker syndrome

****
St 1
Ascites + Jaundice
Bronchiectasis

St 2

25 years lady diarrhoea
IBS, Coeliac disease

St 3
MVR
Spastic paraparesis (Lower limbs)

St 4
SAH , LP procedure explanation, DAMA

St 5

*30 yrs man giddiness 4-5 days

*21 years old man T1 DM diagnosed for 2 years, now presented with DKA.

Pondicherry

2/24

****
Communication 1 : theophylline toxicity leading to seizure, patient concern was why it happened, why you screwed up and gave such drug, what will you do now with theophylline since I have copd, sole earner in family and dependent members, drive as a job, can't leave the job due to dependency…

For comm 1 Patient was allergic to penicillin so given clarithromycin, which interacted with theophylline.

Comm 2: elderly female with previous breast cancer with lumpectomy and chemo, was admitted with asthma 6 wks ago, had faint 2 opacity suspicious, which after 6 weeks of repeat xray didn't change, asthma well controlled now with spirometry testing..

But patient wasn't communicated about those opacity and now patient needs to be conveyed about the miscommunication and inadequate documentation..

Patient upset and worried as she has cancer, and sister passed away as cancer was detected late , so now patient upset, angry and worried..should she receive chemo now and what are doctors going to do about her opacity which remained the same even after 6 weeks..

Lcc : young man with fever diarrhoea for 3 days, palpitations for 1 month
High and wide pulse pressure with tachycardia

Examination findings of hyperthyroidism with goitre, but was confused if he also has marfanoid features and had systolic murmur , so wasn't able to correlate hyperthyroidism and pansystolic murmur present..

Questions about clinical findings, hyperthyroidism cause , differentials and management..

Concerns, what's wrong, why it happened and how to manage..

Lcc 2 : skin tightening and black and white discolouration of skin, but no other manifestations, felt as limited scleroderma

Concerns : is it contagious, what's wrong ? Is there any cure, and what to do about skin tightening

Respiratory: exacerbation of copd, as patient had polyphonic wheeze all throughout,

Cns spastic paraparesis , differentials, features of compressive myelopathy, infectious causes of compressive myelopathy, they want to know TB..

CVS ar and Mr, differentials of diastolic murmur, how to differentiate ar and pr, management and treatment

Abdomen jaundice splenomegaly and ascites, with small scar over right hypochondriac region, with big transverse scar from rt lumbar to umbilical region, (?) Transplant or open cholecystectomy not sure, didn't say anything

My diagnosis, why limited scleroderma , she had dysphagia and exertional breathlessness so why she is breathless and differentials of breathing difficulties in scleroderma

How to investigate and antibodies mention..
Complications of scleroderma

*****
Puducherry 2nd round
8.8.24
LCC1 : Diffuse Systemic sclerosis with Anaemia
Family history of Type I DM in her son
I said that I want to do investigation for pernicious anaemia also

LCC 2 : Solitary thyroid nodule with hyperthyroidism presenting with palpitations for 1 month with fever, loose motion for 3 days
Examiners ask role of surgery and possible complications if plan to do surgery now

Abdomen examination
Moderate splenomegaly with mild hepatomegaly with incisional hernia in lower abdomen
Examiners ask DDx, cause of abdominal pain in this patient

Respiratory examination
upper lobes collapse with trachea shift with bronchial breath sound
Examiners ask causes - TB, Malignancy
Treatment of Pulmonary TB

Cvs Examination
Mitral stenosis with AF
Heart sounds not heard properly and pt is obese

Neuro : MS or FA with asymmetrical sensory loss with lower motor neuron weakness and cerebellar sign
No time to do heel shin test

Comm 1 : Anaemia with underlying MI not need for PCI and on dual anti platelets went to GP and Hb was reduced to 7.7 g% which was previously 11.5g % and 14g% years ago
Patient concern was why he was not informed at previous admission about anaemia
Surrogate ask will you do blood transfusion or not
I said yes because you have underlying IHD but I have to inform my consultant for that

Comm 2 :
Patient with CKD and DCM with EF 20% present with dyspnoea
Pt got vomiting and feeling sick 3 days ago
Pt got arrhythmia and bradycardia and despite CPR, she died
Reviewing the chart, digoxin was in the drug chart due to re - typing error which is meant to be withholding because the drug level result not come out
Have to explain to patient daughter who has come to collect the death certificate

****
Com 1. Patient with swallowing difficulty later found out to be oesophageal cancer. Consultant explained operable first but on CT scan for staging revealed that inoperable with liver metastasis. The oncologist decided to give palliative chemo.Explain the CT result and plan.
Com 2. Old lady admitted with back pain due to osteoporotic fracture. She's been taking prednisolone 15mg for nearly 10years for her skin allergy which is given by her GP.Last 2 yr ,Calcium,vit D supplement and Bisphosphonate have been added to her medication list. Now found out to be high BP and glycosuria on admission.Patient has cushingoid features and explain the management and address concerns
LCC 1. Cough for 3 months now more breathlessness in outside scenario. Inside pt also has joint pain. Pt is barber. Turned out to be ILD with RA
LCC2 abnormal shaking of the hands and difficulty to walk (Parkinson)
CVS MR
CNS Stroke
Abd massive ascites with transverse scar which seemed to be umbilical hernia repair and nutritional dermatitis lesion on skin(COL with PHT with massive ascites)
Resp ILD u/l RA
My cases from Puducherry

[09/08, 6:02 am] Dr. Masrur Siam Vai Synapse: Pondicherry Day 1 Carousel 2

Communication 1:Medical error:wrong administration of Digoxin leading to death of parent,talk to son(Patient had HF,CKD,vomiting,plan was to withhold Digoxin)

Communication 2:
H/O MI,was getting anti platelet,Hb level was decreasing(14-11-7).Now talk to patient for further Mx.

LCC 1:
Skin tightening(SS) Dummy patient.
No sign.
Dysphagia present.

LCC 2:
Palpitation

Thyrotoxicosis(goitre)
High Temp,Pulse-Very high.
Patient's current status?
Any grave complication?

Cardio:

AF+MS+/-MR

Neuro:

Walking difficulty,examine neurologically.(Hemiplegia)...35 year male.

Abdomen:

Hepatosplenomegaly +/- ascites(abdomen was hugely distended)
Crossing was aetiology without ascites

Resp:

Upper Lobe Fibrosis/Collapse
(Depressed chest wall,deviated trachea,Bronchial breath sound,creps+/-)
(Some said Fibrosis,some collapse)
[13/08, 12:32 pm] Dr. Masrur Siam Vai Synapse: Pondicherry Day 2,Diet 1/2024,1st-2nd Carousel

Communication 1
nafld

Communication 2
brain tumour BBM

Lcc
Tia/AF

Lcc
psoriasis

Abdomen
esrd with ascites (?ADPKD) with active fistula

Respi
Bronchiectasis with lower/upper lobectomy(unsure)

CVS
tof

Neuro

spastic paraparesis
[13/08, 7:00 pm] Dr. Masrur Siam Vai Synapse: Pondicherry Diet 2/24,Carousel 3,Day 1

Cardio:MR with P.HTN
Neuro:Stroke
Abdomen:Ascites
Resp:RA with obstructive airway disease(?)
LCC:PD
LCC:RA with DPLD(SOB for 7 days,SpO2-92%)

Pondicherry exam centre

Neurology station- Asymmetric spastic paraplegia

Cardiology- AS with AR / Dysmorphic facies

Communication- Asthmatic patient recently admitted and CXR was done and there were two opacities. Was not mentioned in discharge summary and not communicated to the patient. She previously had a breast cancer- lumpectomy and chemo done - has been on follow up. Sister also had cancer. Six weeks later she has come. Repeat xray has no change. She is irritated that X-ray finding was not informed to her and is concerned that it may be cancer. Explain the POA

Abdomen- deeply icteric young boy with clubbing, moderate splenomegaly and a transverse abdominal scar

Consultation- Systemic sclerosis with tightness of skin, microstomia, has dyspnea on exertion but cvs and rs normal

Communication- 35 yr male with copd on theophylline, came with pneumonia- given clarithromycin- was getting better- then developed seizures- theophylline levels were not checked- consultant said theophylline toxicity due to clarithromycin interaction
Then levels were checked and were high. Had to Talk to the angry patient

Respiratory- A/E COPD

Consultation- young man with three months palpitations- worsened over ten days
Now came with fever, diarrhoea, breathlessness
PR- 160 Irregular
BP 180/50
Had diffuse goitre ?Mng
Had MR murmur also

Puducherry- morning- 9.8.24

Lcc1. TIA , 68 years

Lcc2. Psoriasis

SHORT CASES= CARDIO VSD with reversal of shunt

NEURO = spastic paresis with dissociative sensory loss

RESP = Left pneumonectomy

Abdomen = CLD

Communication 1 = explaining NAFLD and talking about lifestyle changes

Communication 2: explaining about glibastoma multiforme and planning for biopsy. And diagnosis and treatment options.

Pondicherry Day 1 Carousel 2

Communication 1:Medical error:wrong administration of Digoxin leading to death of parent,talk to son(Patient had HF, CKD,vomiting. Plan was to withhold Digoxin)

Communication 2:
H/O MI,was getting anti platelet, Hb level was decreasing(14-11-7). Now talk to patient for further Mx.

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High Temp,Pulse-Very high.
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Crossing was aetiology without ascites

Resp:

Upper Lobe Fibrosis/Collapse
(Depressed chest wall,deviated trachea,Bronchial breath sound,creps+/-)
(Some said Fibrosis,some collapse)

1/24
******
3rd carousel pondicherry

CVS : AS with AR
CNS: umn lesion asked only motor , location of the lesion: spinal cord .

RS: lobectomy underlying BRONCHIECTASIS
Abd : HSP with jaundice hemolytic anaemia with open
 chole scar

LCC: thyrotoxicosis,
LCC 2 : known case of Mg, suddenly developed difficulty to swallow and speech , Mg crisis vs Cholinergic crisis .

Communication: error , PD staff nurse not given one dose , IR , apologies,

Communication: admitted pt ,had black heel ulcer developed, 2 days . Apologies, IR,
*****
Today Pondicherry morning 11:30 cases
LCC 1: psoriatic arthropathy
LCC 2 : COPD a/c exe:

Commu 1
Advanced Parki with Dementia for feeding options

Commu 2
Advanced COPD , Patient competent decided not to continue NIV , told the daughter about the decision

CVS MR

Neuro Spastic Para
With spinothalamic + dorsal column on Rt side
Normal sensation on Left

Respi Pulmonary fibrosis may be due to RA
Ulnar deviation + joint deformity
Abdo Huge Ascites with splenomegaly cirrhosis of liver.

******
St 1 : Delirium pt, Urosepsis AKI, Admitted, IV fluid+Antibiotic given, AKI improving, Pt developed Black heel ulcer in foot.

Resp : Lt Lat Lobectomy Scar + Bilateral Bronchiectasis + Clubbing

St 2 LCC : Dx cases of Myasthenia Gravis. Taking Pyridostigmine, Prednisolone, Azathioprine. compliance.

Last 2 days SOB,Dysphagia,Double vision.

No H/O infection, Stress or any drug.

St 3 : CVS : Don't know, 2 said MR, 1 said MS, 1 said AS AR, I said AS.

CNS : Examine Motor system Bilateral Lower Limb UMNL + UL Triceps exaggerated

St 4 : Parkinson Admitted + Missed medication
Abd : HSM+Jaundice+Scar

St 5 LCC: Weight Loss+Loose stool + Racing+Vision problem, Graves disease

*****
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[*********
Pondicherry today

1. Lcc : myasthenic crisis..there was no drug cause ..i have said infection
2. Lcc : wt loss due to thyrotoxicosis..one said murmur but i didn't.
3. Cardio..MS e p htn..couldn't found murmur ..found 1st hs loud
4. Rsp.. Thoracotomy scar e bronchiectasis
5. Abdomen.. HHA e scar e jaundice
6. Neuro..cervical myeloradiculopathy

7. Commu..PD pt admitted e cap..missed PD med..error
8. Commu..dementia pt urosepis admitted then developed bed sore

****
I believe these are the cases 3 rd day ; 3rd carousel pondicherry

CVS : AS with AR
CNS: umn lesion asked only motor , location of the lesion: spinal cord .

RS: lobectomy underlying BRONCHIECTASIS
Abd : HSP with jaundice hemolytic anaemia with open
chole scar

LCC: Weight loss - thyrotoxicosis,

What do you expect in the heart of thyrotoxicosis pt ?
Apart from afib?
I said Thyrotoxic cardiomyopathy. Cardiomyopathy, afib.
They asking anything else? .....
I was just , high output failure

LCC 2 : known case of Mg, suddenly developed difficulty to swallow and speech.
Mg crisis vs Cholinergic crisis .
Advance treatment.
New molecules?
Mechanism of action of IVIG.

Communication: error , PD staff nurse not given one dose , IR , apologies,

Communication: admitted pt ,had black heel ulcer developed, 2 days . Apologies, IR,

*****

Puducherry 3rd Carousel yesterday :

LCC 1 - Rash v : Psoriatic arthropathy

LCC 2 - Chest pain - ACS with metabolic syndrome

Cardio - MS with CMC scar

Neuro - Spastic Paraplegia

Abdomen - Alcoholic CLD, Dupuytran Contructure

Respiratory - infectious exacerbation of COPD

comm 1 : hypoglycemic unawareness

Comm 2 : TIA, af. Counselling for anticoagulant

******
Neuro: spastic paraperesis with cerebellar signs

Cardio: MS with AF.

Other examinee basal creps also.
Question: Radiological findings of Heart failure.

Resp: Right sided collapse

Abd: Young boy with deep jaundice, splenomegaly, tattoo & transverse scar on abdomen

(Abdomen:
Anaemia, Deep Jaundice, hepatosplenomegaly (hepatomegaly very hard to find)
No ascites (though look like distended abdomen)
D/d:
1. Chronic hemolytic anaemia
2. Lymphoma
3. Chronic infection (TB)

Question about
Cause of Jaundice in CHA AND LYMPHOMA
Then
CHA in details.

Com 1: DNAR (Ca breast with mets)

Com 2: error (missed anti epileptic drug during stay in hospital)

LCC 1: weight loss, diarrhoea (Grave's disease with AF)

LCC 2: SOB (ILD due to RA)

Pondicherry today’s carousel
****
Today's Puducherry
 Lcc

1.vitiligo with addison

2.Dm with empa UTI/ pyelonephritis

 Comm
Aspirin s/e, concern is Allergy

Mtx induced pneumonitis,

Cardio :TOF (vsd, ps)

Neuro :MND or motor neuropathy (command on UL, all r LMNL

Abdomen : CLD (huge ascites) lots of stigmata

Respi : Left thoracotomy scar
But bL feature of bronch
Trache not sure

****
Cardiology- MS, MR, pul HTN, AF
Respiratory- Pleural effusion
Abdomen - ESRD, huge ascites
Neuro - pt with clumsiness, examination for motor system, findings were bilateral hand muscle wasting, claw hand, reflexes absent both UL and LL, plantar extensor bilaterally, I said cervical myelopathy with peripheral neuropathy, MND, SCD but I forgot to check cerebellum. (neuro was confusing for all, examiner was terrifying)

LCC-1. Episode of speech difficulty and Rt sided weakness for 45 min.

Dx- TIA, AF

LCC 2- Wt gain, fatigue for 5 months -

primary hypothyroidism with DM

Communication -1 Polymyalgia rheumatica, explain diagnosis, counselling for treatment, association and future prognosis.

Communication 2 - TIA, 24 hrs holter ECG shows AF, explain AF and counselling for Apixaban

****
Pondicherry 3rd day 1st carousel
Station 1
Communication- Advanced PD with Dementia with aspiration pneumonia, not to go for you invasive procedure
Respi....ILD with RA
Station 2 LCC
Chronic skin rash..... Psoriasis
Station 3
Cardio.....MR with pul HTN
Neuro.....RSHP
Station 4
Communication- COPD with type 2 RF, Patient declined for NIV, consult agreed to continue treatment but stop NIV, talk with daughter.
Abdomen....HSP with ascites, LN
Station 5 LCC
SOB....COPD, Asthma, PE
******

COPD
CVA - stroke
Decompensated CLD
Ms with PHTN , Afib, pronator drift

Com 1 is DNR
Patient is already stable
U have to explain when she deteriorated.
Real scenario is : She has underlying Ca with bone mets. Now admitted due to severe CAP

Weight loss with diarrhoea
They didn’t happy with thyrotoxicosis

Weight loss with diarrhoea
Thyroid
Addison
Malignancy
Celiac
Chronic pancreatitis

(
LCC: I believe : diarrhoea due to
1) uncontrolled thyrotoxicosis 2) due to drug carbimazole 3) addison 4) celiac 5) opportunity infn secondary to carbimazole

Should not forget infections like HIV, Giardiasis, intestinal TB.)
****-
★ 100 times doctors aspirin Allergy main concern
Pt came chest pain dx nstemi,angiogram angioplasty done pt stable,give asp,clop,bis,rmi,sta
5 yrs back gi se aspirin but wife told that was Allergy but all record showing not Allergy just se
So wife angry why give aspirin

★ Mtx pneumonitis after Lung FT and ct,
Pt dx RA,on mtx long time
After dx mtx stopped,pred Start
But pt pain not Control wants mtx AGAIN and again even low dose (main concern)
Is it reversible? How long pred,? Wt gaining?
Give alternate med for RA

★ My abdomen was
Inside sign got
Small m wasting hand,leukonychia,gynecomastia,huge ascites, no organomegaly,fluid thrill and SD positive, b/l leg edema.

Dx i told D- Cld due to.....
Then go for ascites questions : Cause, SAAG details, mx, complications.
SBP mx dx Rx

★ My Resp was Left thoracotomy scar, b/l bronchiectasis. Coarse creps, clubbing, polycythemia, leg edema,above and below scar BS is bronchial and increased VR. trachea central.

Ask--- which side has more Bronch? Rt>left.

Then go for bronchial Details.
Ix,mx,complications, sputum test.
Ask what is the causes this pt, i told TB(exam smile and told mycob tb 😁)

Then tb test,long term mx of broch,

★ LCC
Vitiligo for 40 yrs, only associated addison dis

Exam q.
Dd for rash- vitiligo,leprosy, versicolor

Ask why u chq sensation? neck?

Ans to exclude leprosy, thyroid

2 times told I want to do a postural drop (no answer).

Ask q for mainly 3 inv of addison(ask apart for short synacthen test 🤭)
Actually he wants to know hyponatremia ,hyperkalemia ,hypoglycemia (upto this asking anything 😁)

★ LCC -2
Outside :-- pain right lower back with fever.

Inside : old lady 70 yrs with catheter, cannula both hand and very toxic.

All r 2 days, bunnings micturition also
K/c/o DM on dapagliflozin.
Allergy to penicillin.
H/o renal stone long back.
no travel history abroad but frequently visit another town.
No other complications of DM.

Examination :
Do very less, pts toxic.
examiner told, do with minimal manoeuvre.

Dx pyelonephritis.
Dd drug ind uti.

Admit and fluid given.
Then ix, mx. mistakenly I was told cephalosporin antibiotic. then correct to cipro.

Then a lot of q (i can't remember bec Answer i don't know)

★ Cardio station
Inside 25 yr boy
Clubbing, polycythemia,pulse ok
Not Raised JVP,apex not dis
Systolic murmur (LSE,aortic, pulm,mitral area) more in LSE
B/l leg edema
I could not appreciate any radiation to axilla or carotid
I told VSD,PS,MR
Crossing was not good
Maybe i missed the case 😔

★ Neuro station:
Commands on UL
Inside
Wasting,
Hypotonia

power 0/5 left,3/5 right
Areflexia
Sensory intact
Back:- normal
LL:- planter up going both, co ordination intact,gait normal
CN:- i do 7 th normal, tongue- no fasciculation.

I told d/d :
Motor neuropathy with causes.
Crossing was good but i missed to tell MND.
So i think i missed the case 😔

****
2/23

PUNDUCHERY CASES

MRCP Paces

St4:
End stage alcoholic liver disease e renal function deteriorating. Treating team doesn't think liver transplant would work now. Want to carry on with ongoing mx. No invasive procedures to be done.. councell regarding resuscitation mx + other concerns..
(Both british examiners, asked me in one question, do you practice that in India?. I said, i am from Bangladesh Mam, i have no idea what happens in India , then they laughed)

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St 1
Abd - hepatomegaly +jaundice (ascites +/-)
Respi - left sided pleural eff with lymphadenopathy

St 2 -
Known case of type 1 presented with recurrent vomiting
(I thought Addison ,latter turned out to be gastroparesis)

St 3 -
CVS : AVR
Neuro - brainstem stroke (?)
Instruction were examine the motor system
Upper motor neuron lesion in left plus cerebellum was there (
Multiple sclerosis/ brainstem stroke?)

St 4
Medical error (Mtx+ trimithoprim)

St 5
Bcc 1
K/C/O COPD
Now come with sob,cough with blood for 5 days
has H/O leg swelling 3 months back
I said pulmonary embolism,AC ex COPD, malignancy
Bcc2-
Psoriasis.

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MRCP Paces

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Crossing was on causes of ILD and investigations

Station-2: 47y man with peripheral sensory neuropathy for 4m. Takes 20units alcohol weekly, H/O unsafe casual contacts, h/o taking metronidazole 6m back and works in a metal company. Told DD HIV, alcohol. Examiner was unhappy for not exploring metal company job further.

Overall left a very unhappy set of examiners behind 🙁 Better luck to me next time. And Good luck to everyone.

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Resp:
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BRONCHIECTASIS(Left lung predominant)
Upper lobe fibrosis(Rt)/
Fibro cavitary
Pleural effusion

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PUNDUCHERY CASES

MRCP Paces

Abdomen:
Hepatosplenomegaly
Splenomegaly with jaundice
Tender hepatomegaly with jaundice
Ascites

Cardio
AR
AS/A.sclerosis/HOCM
MR,MS,AR,AF
MR
MS

Neuro
Left 6+7 palsy
Spastic quadriparesis
Bell's palsy
Left hemiplegia
Right hemiplegia in young

BCC:
Psoriatic arthropathy/Psoriasis
Uncontrolled DM with retinopathy/Fundus korte boleche
Vitiligo
DVT
TB/BRONCHIECTASIS/CA Lung/aspergillosis(cough,hemoptysis,96%,cachetic patient,left upper fibrocavitary lesion,farmer)
Papilloedema

Myelgia and tiredness
2.Low back pain for 2 month 61 yrs old lady after a trivial fall
3.occupational asthma
4.ihd
5.stroke /complex migrane

Station 1 :
Abdomen: Middle age gentleman with Hepatosplenomegaly
Respiratory:
Acute ex of COPD, D/D Brochiactesis

Station 2 History: 26 y Women with Palpitation, Coffee shopkeeper, H/O Anxietic disorder taking Sertraline,
H/O father died @42 y due to cardiac cause .
D/D: Coffee induced, Anxiety, Familial Heart disease

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Medical Academy

PUNDUCHERY CASES

MRCP Paces

Station 3:
Cardiology: AS with Heart failure
Neurology: Hemiperesis

Station 4:
28y women air hostage with new diagnosis of UC...councelling...Hidden concerns: BBN, Job, Family planning and false certificate

Station 5 :
1. 55y male with Abnormal sensation in rt hand
Dx: PD
2. 36 y male with polyurea.
O/E: B/L ballotable kidney and painful. No fAmily history. H/O constipation and polyurea.
D/D:
Hypercalcaemia
Due to
1.Tertiary Hypercalcaemia with ADPKD,
2. Other cause of hypercalcaemia

DIET 2 2023
Thiruvannanthapuram cases..

Station 1, Left nephrectomy with Right ADPKD with functioning AVF. COPD with superadded chest infection

Station 2, Post covid with dizziness and palpitation, underlying controlled bronchial asthma

Station 3 , PSM radiate to axilla with midline sternotomy scar with no click, LMNL with no sensory involvement.

Station 4, Type 1 DM with all complications and recent hypoglycemic attacks, talk to reduce tight glycemic control.

St 5 (1) difficulty in using hands with infertility.. Myotonic dystrophy,
(2) Young lady with left sided headache with increase BP...Tension Headache/Migraine
These are today

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SYNAPSE
Medical Academy

PUNDUCHERY CASES

MRCP Paces

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These are today

Diet 2 Thiruvananthapuram

BCC1- Heditary Angioedema
BCC2- Neurofibromatosis
Abdo - ADPKD on HD
Respi- Bronchietasis
CVS- VSD
CNS- Surgical 3 rd N palsy
Com- IBS and Amitriptylline
History-RA pt worsening of SOB currently on Methotrexate and Anti- TNF

Station-2 Dizziness & palpitation 2 weeks , just differential
Station 4 - hypoglycemia unawareness issue

Diet 2, kerala india

Station 1
Bronchiectasis/ild
Clubbing/chest crepitation
Abdomen
Jaundice with hepatomegaly/evident splenomegaly

Bcc
Young lady with left side weakness ..
Head ache /tuberous sclerosis
Cvs
Aortic valve replacement with CABG
Communication
Mitral valve replacement pt had IE need to start antibiotics not willing to stay in hospital...talk and concern
Cns case still i am not sure i did not get time to complete

History /post partum thyroiditis

SYNAPSE Medical Academy

PUNDUCHERY CASES

MRCP Paces

Resp : Bronchiectasis
Abd: ADPKD with nephrectomy scar
cardio: MVR
Neuro: Motor Neuropathy
St-2 : Post covid syndrome
st-4 : Hypoglycemic awareness
st-5 :
1. Myotonic dystrophy
2. TTH (dummy)

Resp : COPD + Bronchiectasis Probably
Abd: Jaundice, Liver
Heart : MR MVP

Neuro: CMTD/ CIDP
St 2: Chest pain
St 4: PC suicide (not psychiatric, impulsive)
St 5:
1. PsA
2. IBS (Not sure)

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Medical Academy

PUNDUCHERY CASES

MRCP Paces

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Now come with sob,cough with blood for 5 days
has H/O leg swelling 3 months back
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SYNAPSE Medical Academy

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SYNAPSE Medical Academy

Diet 2 2023
pondicherry india
PODUCHERRY DIET 2 23
******
1. Lt sided pneumonectomy due to Bronchiectasis
Clubbing present
2. Chronic liver disease.

Ascites, Dupytrens' contracture, tattoo mark, Due to Alcohol.
3. B/L cerebellar syndrome with PN due to Alcohol
4. AVR with AS AR MR
Gynecomastia, low volume pulse.

Station 5
 Vitiligo
Description, Association,D/D.

2. IDA due to past history of Abdominal surgery.
Koilonychia, Abdominal scar mark.

*****

St 4
Urgent endoscopy done for regurgitation and vomiting, was unsuccessful due to a large pharyngeal pouch. This was diagnosed 2 years back on barium swallow. Patient has no red alert symptoms like anorexia or weight loss now. But father and brother have a history of cancer and so she is concerned if she also has cancer.
Task is to exp dx and cx.

Bcc 1
Psoriasis
Bcc 2
Ll edema
Inside anasarca

Resp
Left sided fibrosis/mass lesion with cachexia

Abdomen
Hepatosplenomegaly with Jaundice

St 2
Monoarthritis
Cvs
MR with AF
Neuro
Peripheral Sensorimotor neuropathy for dd

****
 Respiratory left side pneumonectomy

Abdomen ascites plus jaundice anaemia plus dupuytren contracture plus tattoo mark

St 2 palpitations
St 3 cvs AS
Neuro don't know what it could be bilateral cerebellar sign were there

St 4 medication error asthma patient with heart failure given beta blocker

St 5 bcc1 vitiligo
Bcc2 tired plus sob due to anaemia due surgery in abdomen

****

Cvs- vsd
Cns- HSP
Rap- Copd with b/l fibrosis
Abd - alcoholic cld with ascites

Station 5 - ankylosing spondylitis
Rash with itching - urticaria

History - ppi and nsaid induced acute interstitial nephritis

Communication - breaking bad news and explain diagnosis of MND

****
Pondicherry day 3 1st carousel
St1
Resp- ILD
Abdomen- Decompensated CLD with ascites, jaundice, tattoo, dupuytren's contracture

St2- acute interstitial nephritis due to ppi, nsaid

St3-
CVS- TOF (vsd, clubbing, cyanosis, raised jvp)

CNS- spastic paraparesis with intact sensation

St4- BBN of mnd

St5-
Bcc 1- ankylosing spondylitis

Bcc 2- black palpable itchy rash on flexural surface & extensor surface for 6 months (occupation farmer for 2 years). No other positive history.

Some said eczema, some said lichen planus

*****
Stn 3
CNS Cerebellar syndrome

CVS not sure told MS
People told it was AR

STN 4
Beta blocker in asthma

Stn 5
Bcc1
Vitiligo
Bcc2
? COPD
PT HAD FEVER ,BREATHLESSNESS PAST 8 months iron deficiency anaemia

Stn 1
BRONCHIECTASIS + lobectomy
CLD + Ascites

Stn 2
PALPITATIONS

****
Station 2-63 old lady complaining of headache..more in the morning..
Past history of Stoke and weakness..
Viva on SOL.

CVS-MR
CNS Spastic paraparesis with normal sensation..viva on multiple sclerosis.

Station 4.,,Diabetic elderly patient age 80,having hearing issue ,secretary called for telephonic consultation.
Talk with the daughter. Daughter told that no telephonic call was received.
She wants to take live consultation instead of telephonic one.

Station 5.
1.Bell's palsy.
2.Vitiligo.

Station 1.
Chronic hemolytic anaemia.
COPD

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Psoriasis.

*****

I am sharing my exam experience. I feel my exam was not good. I am just writing what i felt....

Apart from me, Other 4 candidates were from South India. They said, they got puzzled too..especially at Neuro station...

St1 :

Res : Emaciated elderly pt, percussion dull breath sound diminished, from rt 3rd ICS to downwards, same on back, trachea shifted to right...

I said mass lesion as lung malignancy... Regarding trachea i said i couldn't appreciate bronchial breath sound / any added sound , asked what would you thought? I said collapse/ fibrosis. then inv+mx

Abdomen : Shifting dullness positive + b/l leg edema

DCLD, intra abdominal malignancy / infection... Inv+ mx

St: 45 yr old lady e sudden dizziness, spinning on neck movement, only once happened today morning, having high stressful job for 20 yrs, having anxiety + depression, drug only sertraline 50 mg for 1 yr, ..f/h/o-CVD. Her BP - 160/ 90 mmg....

I said, drug induced, Vertebrobasilar ischemia / TIA, cervical spondylosis.....regarding dd + Inv

St -3

CVS : your boy e AS+AR

Neurology : Difficulty in walking, examine the **sensory system**...

I found nothing on the sensory system... examined upper then ...checked gait...

Said Parkinsonism, said some d/d....(in this station everyone was puzzled)

don't know what they actually wanted.

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St-4: MGUS (surrogate was repeating the same question again and again in a Tamil accent so wasn't sure whether she wasn't getting me or i wasn't getting her)

In crossing they asked why NT-pro BNP was done which was mentioned in the scenario. I couldn't answer.

BCC-1 : vitiligo patient with h/o weightloss and recent worsening of rash. Told D/D leprosy but didn't examine anything for that. Examiner was very unhappy abt that.
BCC-2: young man with LBP. Told AS and seronegative DD. Couldn't finish all the examinations. Told I want to do Schober's test and examiner said do but I didn't because 2 min was remaining.

Station-1: Abdomen: Young boy e hepatosplenomegaly e jaundice e a horizontal scar mark extending from rt hypochondriac to almost left side. Told hereditary haemolytic anemia e possible open cholecystectomy. Crossing was on thalassemia.
Respi: ILD e clubbing (said IPF)
Crossing was on causes of ILD and investigations

Station-2: 47y man with peripheral sensory neuropathy for 4m. Takes 20 units alcohol weekly, H/O unsafe casual contacts, h/o taking metronidazole 6m back and works in a metal company. Told DD HIV, alcohol. Examiner was unhappy for not exploring metal company job further.

Overall left a very unhappy set of examiners behind 😂 Better luck to me next time. And Good luck to everyone.
[
****
: Resp:
COPD
BRONCHIECTASIS(Left lung predominant)
Upper lobe fibrosis(Rt)/
Fibro cavitary
Pleural effusion
[17/07, 2:04 pm] Dr Shahinul Alam Synapse: Abdomen:
Hepatosplenomegaly
Splenomegaly with jaundice
Tender hepatomegaly with jaundice
Ascites

****
Neuro
Left 6+7 palsy

Spastic quadriparesis
Bell's palsy
Left hemiplegia
Right hemiplegia in young

******
Cardio
AR
AS/A.sclerosis/HOCM
MR,MS,AR,AF
MR
MS

*****
BCC:
Psoriatic arthropathy/Psoriasis
Uncontrolled DM with retinopathy/Fundus korte boleche
Vitiligo
DVT
TB/BRONCHIECTASIS/CA Lung/aspergillosis(cough,hemoptysis,96%,cachetic patient,left upper fibrocavitary lesion,farmer)
Papilloedema

****
3rd carousel/22

Dear mentors, I think I could not do well. but anyone can benefit from my sharing that's why.please pray for me everyone . If Allah wants any miracle can happen... .

St 5 --- diabetic retinopathy, PD
St4----post MI
St3----MR, myelopathy
St 2----breathlessness, RA,mtx
St1— ILD ,CLD

Pondicherry last diet 3/22
1.
AR ,
right hemiplegia in young man,

hepatosplenomegaly,
right upper lobe fibrosis,

history- occupational asthma and IHD ,

breathing bad news- ckd,

bcc-
psoriasis arthropathy,
uncontrolled DM with retinopathy

2.
History- occupational asthma

Respiratory- fibro cavity
Abdomen- splenomegaly with jaundice

Cns- left hemiplegia
Cvs- AR others told bcz I couldn't identify

Bcc 1 psoriasis
Bcc 2 - diabetic retinopathy. Asked to do fundus

3.
Experience from Dr. Anurag

Copd
Spleen jaundice

PMR(st2)

MR
SP

EAA(st 4)

Bcc1- VITILIGO
Bcc2- TB/ BRONCHIECTASIS/ CA LUNG

4.
: 3rd session today:

Respi: pleural effusion
Abdomen: tender hepatomegaly with jaundice

History: low back pain for 2 months in 61 years old lady after a trivial fall

Cardio: ??MS
Neuro: Bell's palsy

Communication: discharge planning and ensuring safety

BCC: vitiligo
& DVT

5.:

st2 :
Myalgia and tiredness post covid vaccination.
PMR
statin induced Myositis

ST 3:
CVS: there was AF, lots of murmur both systolic and diastolic. I said involvement of both mitral and aortic valve. There was MR and MS. I said AR as well.

CVS:
spastic quadriparesis with intact sensation

st4:
Bird fanciers disease, explain dx, steroid plan, side effects explanation and convince him to switch jobs.

st5 :

BCC1 : vitiligo. with no other association with other autoimmune diseases.

BCC2: Outside info was cough, hemoptysis, wt loss, fever. sat 96%.
inside cachectic pt with left upper fibrocavitary lesion. occupation farmer.
put ddx as lung ca, tb, aspergillosis.

st1:
resp: Bronchiectasis (with left lung Predominantly involved)

abdomen: young boy with jaundice, pallor, abdomen scar, hepatosplenomegaly.
ddx: Cong Haemolytic anaemia
Chr inf
haematological malignancy

6.
Respi: COPD
Abdomen: Ascites

Cardio: systolic murmur in 2nd aortic area. Axilla radiation was there but very low. Apex beat is not shifted, low volume pulse, no neck radiation. the patient came with palpitations. Gave D/D: AS, A. Sclerosis, HOCM. I think it was TR. The lady was asking about other valve pathology.

Neuro: left 6 and 7 nerve palsy

History: stroke/complex migraine

Station 4: delirium

Station 5:
TB/ Ca lung
Papilloedema

✔✔
POndicherry

Station 1

Abdomen: Hepatomegaly ascites jaundice no splenomegaly. parotid enlargement. (Mostly alcohol induced chronic liver disease)

Respiratory: left pleural effusion in young patient

Station 2: a case of poorly controlled Type 1 DM with vomiting and tiredness (DD gastroparesis ..Addison..PUD)

Station 3:
Cardio. Midline sternotomy scar with metallic second heart sound (DD for Congenital AS or PS young patient

Neuro. Was slightly difficult because they asked to examine motor system only in both upper and lower limbs but briefly there was hypertonia with absent tendon reflexes and upgoing plantars with incoordination (patient was having NG tube ..mostly stroke

Station 4: medical error ..patient was taking methotrexate for psoriasis
And given trimethoprim for UTI which led to pancytopenia and epistaxis

Station 5:
Psoriasis
COPD infective exacerbation

"The centre director told us clearly:
We do not need deep knowledge of everything.

And she stressed upon the point that they want a safe pair of hands only ..with good clinical sense not a perfect candidate"

****
50 yr old man with dysphagia for few months but worsen one month
solid > liquid

Lower oesophagus
Weight loss
DDx
I gave Ca Oesophagus
Eso stricture due to reflux
Achalasia
16/16

****
Communication
Talk to daughter
about possible CA caecum with liver metastasis
Plan palliative and discussion with multidisciplinary team
....
Daughter concern
want every possible tx
How long she live
Any facility in this hospital?
Wanna talk with senior
Examiner...
What is the doubt here?
No biopsy yet

****
: CVS....MVR? young male with midline sternotomy scar....no AF...
I can't hear click clearly
at first thought bioprosthesis.. then heard very soft metallic click
other candidates... AVR
CNS...Rt cerebellar lesion
More focus on stroke InVx and Mx
Res....COPD
Abd....Hepatomegaly with leukonychia with clubbing...CLD
BCC 1....Outside lady with breathlessness
Inside.... RA and ILD
BCC 2..
Outside young man with leg swelling
Leg swelling after 6 hr drive
DVT

Kochi,India

1/24

*****

Kochi India

1) ILD - there was cutaneous stigmata of Systemic sclerosis.

Massive Spleen + MILD hepatomegaly (Gave differential for massive spleen)

2) C/o chronic diarrhea in a 24 year old lady.
History consistent with celiac and there was a recent travel history

3) Young stroke hemiplegia
C/o prosthetic heart valve - Aortic + Atrial fibrillation. There was a faint systolic murmur also

4) Explain diagnosis of Multiple sclerosis to a medical student

5) Scenario
1) 50 year old gentleman with first episode of seizure. Only clue given from outside was 190/110 BP
Patient was fully covered. I found a fistula on his left arm. Then he told he is on dialysis. Took more time to identify it as CKD. When I asked about HD he told its due today. And the interval between dialysis was 4 days.
I quickly checked power and neck stiffness and auscultated fistula , renal bruit . Forgot to look for uremic flap.
I told he needs investigation metabolic , urea , and CT.
Examiner asked why didn't you do reflex and plantar.

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60 year old lady with Shortness of breath. clue from outside was normal vitals.
When i went inside there was obvious rheumatoid deformities. There was basal crepitation also. I asked for drug chart. Forgot to ask for investigation chart.
Told as RA with ILD.
Examiner asked to tell the deformities I identified in this patient and drugs for ILD
[22/04, 8:43 pm] +971 55 369 4919: [11-13, 9:42 p.m.] DR SHAHEEN: [11-13, 9:38 p.m.] DR SHAHEEN: Kochi candidates must practice
[11-13, 9:40 p.m.] DR SHAHEEN: Kochi India
1) ILD - there was cutaneous stigmata of Systemic sclerosis.

Massive Spleen + MILD hepatomegaly (Gave differential for massive spleen)

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Told as RA with ILD.
Examiner asked to tell the deformities I identified in this patient and drugs for ILD
[11-13, 9:46 p.m.] DR SHAHEEN: [2022-11-25, 4:21 p.m.] Dr Hashim Cardio Paces: CNS TB spine with spastic paraparesis

Respi Scleroderma ILD

Abdo Ascites with sternotomy scar

Cvs : ? AR (couldn't hear EDM properly, water hammer pulse was classic)

Bcc Homonymous hemianopia, Graves

History NSAID ulcer leading to IDA

communication: colleague missed an incidental finding on MRI
[2022-11-25, 4:21 p.m.] Dr Hashim Cardio Paces: Kolkata centre 25
[11-13, 9:47 p.m.] DR SHAHEEN: [2022-11-18, 6:30 p.m.] Dr Hashim Cardio Paces: Cochin
History : headache? Familial hemiplegic migraine /CVT
2. Ethics :anaphylactic reaction to salad, chef by profession
3. BCC 1 bilateral pedal oedema in type 1 diabetes with breathlessness with hyperrension and hypothyroidism
? Heartfailure? Pulmonary embolism

Bcc 2:neck swelling with CTS. :on prompting patient had previous pleomorphic adenoma...? Recurrent /hypothyroidism
4.neurology : peripheral neuropathy
5.CVS:ESM....not sure which one.. Radiation to neck...? AS
6. Abdomen :splenomegaly
Resp :pneumonectomy
[2022-11-18, 6:30 p.m.] Dr Hashim Cardio Paces: PACES kochi November 22 :

Station 3
CaVS - AS
CNS - peripheral neuropathy - stocking distribution of sensory loss + posterior column involvement

Station 4 - breaking bad news - young guy oesophageal cancer with Mets - he was keep on asking about liver transplant, finally didn't accept it.

Station 5
BCC 1 - RA lady with breathlessness
- ILD ? Methotrexate induced ? RA related.
BCC2 - 50 yr male fever + chills + rigor - CKD on maintenance hemodialysis, had it post dialysis, searched for access nothing was there, then it was a femoral cath - said it as catheter associated blood stream infection

Station 1 -

RS - had no idea - some VATS scar was there

Abdomen - didn't get any finding apart from transplant scar. No fistula, So guessed it to be functioning renal transplant - kad lots of purpura and telangiectasia over body - so s/e of immunosuppression ? Steroid purpura

STATION 2 :
Dysphagia scenario - mechanical - young lady, c/c smoker ca, prev history of foreign body removed 15 yrs back - ? Structure ? Caoesophagus, concern was worried about weight loss
[2022-11-18, 6:30 p.m.] Dr Hashim Cardio Paces: Cochin November 22
History : headache? Familial hemiplegic migraine /CVT
2. Ethics :anaphylactic reaction to salad, chef by profession
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6. Abdomen :splenomegaly
Resp :pneumonectomy
[2022-11-24, 2:16 p.m.] Dr Hashim Cardio Paces: Resp-copd
CNS myesthenia-
Abd ckd renal transplantation with abd distension
CVS vsd Eisenmenger
Bcc
Tremor

Cushing
History psoriatic arthritis's
Communication dementia-lrti -lorazepam- cardiac arrest to talk to daughter
[2022-11-24, 2:16 p.m.] Dr Hashim Cardio Paces: Cochin
[11-13, 9:48 p.m.] DR SHAHEEN: My cases in Kochi on 17th Nov

BCC1 , sudden palpitations in a patient with recent heart attack

BCC2 Ankylosing Spondylitis

RS - Right Lobectomy

Abdomen - CKD , fistula but not active , abdominal scar was in the hypogastrium but couldn't palpate kidney not sure about transplant

CVS - Probably AS with AR with controlled AF

Neuro - maybe motor neuron disease , they discussed myasthenia , he has ptosis , patient with facial palsy ? U/L or B/L , wasting of masseter , tougue fasciculations power in UL less , fasciculations in upper limb also

History Chest pain , patient has recurrent anxiety attacks on diazepam , glucosuria .. had weight loss — ? Anxiety related chest pain , ? Diabetes ? Pheochromocytoma not sure .

Communication and ethics - Medical error . Sister gave another patients tablets to a patient .

****
Paces diet 1 kochi scenario

Communication 1
24 year old female admitted for pneumonia . Given actrapid 20 u nits instead of mixtard . Patient hypoglycaemia treated with sugar water. Upset with that.
Communication 2 . Young patient diagnosed with diabetes mellitus last admission and started on Metformin. Tests - gad and islet cell antibodies are negative , false negative 10% , bmi 45 , drinks alcohol and smoker . Worried that it is type 1 diabetes mellitus and he might need insulin . Also it might affect his driving. Sugars have come down from 22 to 12 , but symptoms remain. Discussed about life style also.
Concerns - is it type1 DM
How effective are those tests
Do I need insulin
Do I need to stop driving(this was unprovoked)

Resp - clubbing , multiple icd marks on right side . Apical fine creps and left lower zone fine creps , no change in character on coughing . dullness and decrease air entry at right apex . No palpabe P2 , but bilateral pedal edema was there. discussion was about ild and bronchiectasis . How to differentiate. Role of Ct scan
Which other make u think it might be bronchiectasis during examination. ?

LCC 1-elderly gentleman with 2 episodes of dizziness
History - valve surgery not sure
On warfarin , oha , bisoprolol .
Vitals - hr -40
Bp 90/50
Examination . Midline sternotomy scar / ejection systolic murmur most likely , second heart sound metallic in aortic area , no creps , pedal edema
Concern was whether patient need pacemaker .
Lcc 2 - palpitations since 3 months and breathlessness - 2 years gets better with inhaler
On carbimazole
Resting HR 112
Left gland of thyroid enlarged. Could not find any wheeze . Difficulty in speaking .
Discussion was beta blockers can be given or not. Whether will we give if wheeze was there.
Also on radioactive iodine .
Most likely breathlessness was added for copd .
No clinical signs and symptoms of copd and not diagnosed with copd or asthma . I mentioned that breathlessness might be retrosternal extension but able to get below swelling other possibility might be tracheomalacia
Abdomen - massive hepatomegaly with skin discolouration- massive hepatomegaly , no spleenomegaly , ascitis , jaundice Discussion was on CLD
CVS - diastolic murmur more prominent in aortic area but also heard in mitral area- god only knows what is the diagnosis . Discussion was on dual valve diseases and etiology .

CNS stroke in young. Examine lower limb No lower limb signs except for plantar extensor and circumduction gait. Upper limb weakness and facial nerve palsy was also there. Discussion was on stroke on young . Why lower limb sparing is there.

*****
Communication : Parkinson with dementia admitted with cap but not getting med of parkinson

Communication
Seizure CT scan done need MRI

Lcc
Seizure after dialysis
Blue colour hand with sob
Tell Raynaud's with ss

Respi couldn't understand
But crossing on ild

CVS systolic murmur everywhere with radiation
Pulse high more prominent in left lower sternal edge said dd
of systolic murmur
As...vsd...mr
Crossing on as and Mr

Abdomen
Jaundice tense ascites flap
Said cld decompensated

Neuro right upper limb paresis
Then check lower limb
Jerk exaggerated in both upper and lower limb
Ask me do neurotically so said hemiparesis
Cause stroke tumour demyelination

******
LCC 1: pt with fatigue & drowsiness
Dx-hepatic encephalopathy with decompensated CLD(precipitating factor was constipation)
LCC 2: H/o Joint pain & shortness of breath
(No findings was present, no anaemia,no cough, no creps,no pulm htn)
I told all the d/d- anaemia, pulm fibrosis, pulm htn, felty's syndrome, mtx induced fibrosis
(Both lcc lots of crossings)
Cardio- AVR with sternotomy scar,infra-mammary scar
Neuro- peripheral sensory motor neuropathy (diabetic foot present)
Abdomen: av fistula, hepatomegaly,
Dx- ESRD due to adpkd/GN
Respi- left upper lobe collapse
Communication 1: paracetamol overdose, pt wants discharge
Communication 2: lost report of fnac.
(Both surrogate was not good,)

****
Kochi 2nd carousel

station 1-
missing biopsy report

left lung collapse with COPD
I have been asked about bronchial breathing, but I missed it.
Other said fibrocavitary disease

Govt: LCC-hepatic encephalopathy

Station 3-AVR,and peripheral neuropathy

station 4-
Splenomegaly with anaemia.

paracetamol poisoning with DAMA,

Station 5-RA ILD or MTX ILD..

******

CVS was Mr with accessory nipple
Abd was Cld decompensated
Resp was copd with cor pulmonale

Neuro I don't know upper limb spasticity with dysdiadochokinesia.

Neuro case others were saying small muscles of the hand were atrophied

CC- palpitations,

Giddiness and sweating with polypharmacy. IHD, HTN, has midline sternotomy scar & harvesting scar?

Angry patient with mrsa

Aspirin side effect after angioplasty
Angry patient was really angry

****
Kochi 3/ 2023📍
*****
[13/02, 10:05 pm] +971 55 369 4919: *KOCHI DIET 3*

✍🎯
Station 1 communi - u prescribed steroid so avn due to ibd. Pt now wants to complain
Resp :Bronchiectasis

Station 2: pt has ra. Now sob after drug
Methotrexate

Station 3 cvs mr
Cns : stroke

Station 4 : biologic , now latent tb
Abd : adpkd with work8ng fistula

Station 5 : seizure in dm htn ckd stage 5 dialysis
[13/02, 10:05 pm] +971 55 369 4919: *KOCHI 3 rd session 24 Nov 23
*

Station5

LADY WITH NECK SWELLING EUTHYROID

STATION 1

RS ild with left sided bronchoectasis

Communication

Lady with hyperthyroidism explain disease starting of propranolol and carbimazole

Station 2

54 year man with weight loss blood in bowel

Station 3

CVS SYSTOLIC MURMUR AS OR MR

NEURO

CERVICAL MYELOPATHY

STATION 4

communication

Stroke recovered but hemianopia

Want to drive as he is driver

Abdomen

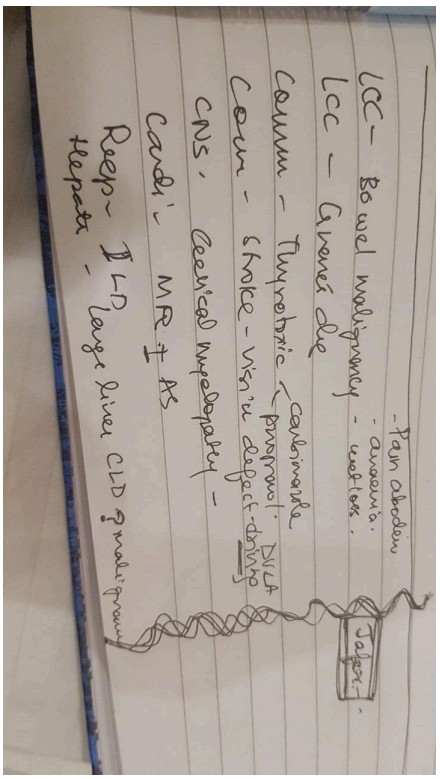
HEPATOMEGALY isolated
[13/02, 10:05 pm] +971 55 369 4919: *Kochi* 2023📍
Consultation 1:
5 Dizzy spells in one year
Was on silodosin
Dutas..
D/d: postural hypotension due to drug
Asked about cardiac murmur
May be AS
2. Pin legs left>rt

Htn dm
Old cabg
D/D pvd neuropathy
3 communication
.Bowel obstruction lymphoma-end of life care
4.communication: Endoscopy clinic
Suspected intestinal mass can't do colonoscopy due to poor bowel preparation
Planned CT
Finished by 7 minutes..no other concern except will my treatment get delayed
5. CVS : Systolic murmur: MR
Asked if MVP
6. RESP: BRONCHIECTASIS
7. NEURO UPPER LIMB : LMN weakness with cerebellar
Wanted Dd
8. Abd. cld
Hepatomegaly with ascites with pigmentation
Dd Haemochromatosis

****
Amar case chara remaining cases were
Lcc sob ..SS with pul fibrosis
Recurrent seizure multiple aetiology

CNS Upper limb MND
Cvs MVR/AVR
Resp bronchiectasis
Abd hepatosplenomegaly
Neuro: lower limb stroke
Abd CKD
Avr
Brochienctesis
Ckd
Stroke

SS
2' htn



******

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****
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Massive Spleen + MILD hepatomegaly (Gave differential for massive spleen)

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History consistent with celiac and there was a recent travel history

3) Young stroke hemiplegia

C/o prosthetic heart valve - Aortic + Atrial fibrillation. There was a faint systolic murmur also.

4) Explain diagnosis of Multiple sclerosis to a medical student

5) Scenario

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I quickly checked power and neck stiffness and auscultated fistula , renal bruit . Forgot to look for uremic flap.
I told he needs investigation metabolic , urea , and CT.
Examiner asked why didn't you do reflex and plantar.

¡¡) Second scenario from outside
60 year old lady with Shortness of breath. clue from outside was normal vitals.
When i went inside there was obvious rheumatoid deformities. There was basal crepitation also. I asked for drug chart. Forgot to ask for investigation chart.
Told as RA with ILD.
Examiner asked to tell the deformities I identified in this patient and drugs for ILD

Another

Abdomen :ADpKD with Hepatomegaly with A.V fistula in left hand

CVS: MVR

Respiratory : Bronchiectasis

Neuro : I don't know. Bcz Pt cant give a good response. I found rt leg planter mute, Left leg plantar extensor. But sensation can't give good clue

I m saying UMNL

St2 low back pain due to celiac and post menopause

St 4: lumbar puncture after CT brain normal in case of SAH

St 5

Psoriatic arthritis

35 yr old Pt dizzy Bp 190/110.
I think it's due to CONNS / **Liddle**

1/23

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(? Uremic encephalopathy)

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Another carousel

S4- newly dx smear positive PTB,, when can fly? If sputum negative after 2 wk can fly or not

Bcc1- DM,HTN,
complained of claudication with foot ulcer

Bcc2 - LOC for 2 min while driving. BP 150/80 on antihypertensive for 20 yrs

S1 : COPD with crackles
Renal abdomen

S2-- headache: O/H fever, neck stiffness,photophobia

S3: ? AS with AR

Left sided hemiparesis
UMNL with sensory impairment

Another carousel

St 1
Abd - hepatomegaly +jaundice (ascites +/-)
Respi - left sided pleural eff with lymphadenopathy
St 2 -
Known case of type 1 presented with recurrent vomiting
(I thought Addison ,latter turned out to be gastroparesis)
St 3 -
CVS : AVR
Neuro - brainstem stroke (?)
Instruction were examine the motor system
Upper motor neuron lesion in left plus cerebellum was there (
Multiple sclerosis/ brainstem stroke?)
St 4
Medical error (Mtx trimethoprim)

St 5

Bcc 1
K/C/O COPD
Now come with sob,cough with blood for 5 days has H/O leg swelling 3 months back
I said pulmonary embolism,AC ex COPD, malignancy

Bcc2-
Psoriasis.

Diet 1 Kochi

Stn5:
50-55yoF
Recent dizzy spells
PMH:DM, HTN,CABG
Systolic murmur on examination ?AS

Young male back pain
Seronegative spindyloarthropathy

Stn1
Bronchiectasis COPD

Splenomegaly

Stn2:
Middle aged female recent stroke, now intermittent headaches with a couple of red flags of ICT.
BG of anxiety/depression worsening lately including losing way in new locality
On Fluoxetine(? Hyponatremia)
No self harm ideation.

Stn3:
As Mr/gallaverdin
Sensorimotor PN middle aged man, didn't allow me to walk.
Had clawing in hands b/l. Not particularly hyper aching feet.

Stn4:
Pheochromocytoma-delayed diagnosis

_***
Kochi 1/23
bcc I messed up, Tricky stations

Station 2
45 year old female with intermittent headache since 1 month and panic attacks and stroke left sided hemiparesis since 6 months

Station 3 peripheral sensorimotor neuropathy

Aortic valve replacement

Station 4 : 5 years headache now diagnosed with pheochromocytoma delayed diagnosis counsel on diagnosis and mx

Station 5: bcc 1 giddiness for 2 days known case of HTN dm and hypercholesterolemia.

Bcc 2 multiple join pains in young for 3 days

Station 1 bronchiectasis
And splenomegaly

****
✅ 24 Feb, Kochi, diet 1 22 22 22 22 22 22 2 2 By Paces network Facebook group

St 2: Osteoporosis in young. Loose stool Wt loss

St 3:
Cardio: MR
Neuro : cerebellar syndrome
Discussion on MS

Station 5 :
BCC 1 : confusion with respiratory symp. Cough ..haemoptysis and wt loss.
DD Causes of confusion
Bcc2 : diabetic with reduce in vision Fundoscopy =normal
Discussion diabetic eye

St : stroke pt Son refused admission
Station 1 :
Resp :ILD
Abdomen : CLD

✅ 14 November diet 3 ✅ By Paces network
✔STATION 4 DRUG ERROR PENICILLIN ALLERGY
✔BCC1 THYROID EYE DISEASE ✔BCC2 MIGRAINE YOUNG LADY

✔CVS AGE RELATED AVD.
✔RS LOBECTOMY
✔CNS YOUNG HEMIPARESIS
✔GIT RENAL TX

✔HISTORY CYSTIC FIBROSIS YOUNG MALE WITH RECURRENT INFECTIONS, STOOLS, INFERTILITY

Diet 3, Kochi, second carousel Started with station 3 CVS: young man with clubbing, sternotomy scar, thrill all over most prominent over the pulmonary, harsh murmur all over most prominent over the pulmonary, I said ejection with regurgitant component CNS: cranial nerves Patient had vertical gaze palsy, checked eye movements twice, after the time was up I realised I should have checked tremor Station 4 Father pneumonia in shock, needs intubation son doesn't want Met all his concerns, (all the same concerns as in previous stations) then the examiner tells me did you inquire about the relationship between the two of them, then bla bla bla Station 5 BCC 1: 55y F, pain in hand and leg Rheumatoid hand,

swollen knee, know Hypothyroidism, bibasal creps with dull purcussion, was taking methotrexate for a very long time, met concerns, examiners asked me wether I looked at the thyroid, I said no BCC 2: 54y M, dizziness with blurring vision, no postural drop Known diabetic, recent changes in medication, checked pulse, heart, carotids, examiners asked wether I checked legs neurologically, I said no Station 1: Resp: ILD underlying systemic sclerosis Abd: splenomegaly Station 2: altered bowel for 6 months, young, mevebarin not effective Patient complaints cramp which relieves after defecating for 9 months, no weigt loss no blood, I said DD IBS, coeliac STATION 4 DRUG ERROR PENICILLIN ALLERGY BCC1 THYROID EYE DISEASE BCC2 MIGRAINE YOUNG LADY CVS AGE RELATED AVD RS LOBECTOMY CNS YOUNG HEMIPARESIS GIT RENAL TX

HISTORY CYSTIC FIBROSIS YOUNG MALE WITH RECURRENT INFECTIONS, STOOLS, INFERTILITY [29/11/2018, 20:28] +91 98859 99262: Station 2 cystic fibrosis Quite ok. Station 4: Medical negligence. Giving allergy medication after informing 1: Abdo : Renal Abdomen, post transplant Chest: post lobectomy Station 3: Mitral valve prosthesis CNS: MND Station 5: Case 1: grave's ophthalmoplegia Case 2: Migraine [29/11/2018, 20:28] +91 98859 99262: Diet 3, Kochi, second carousel Started with station 3 CVS: young man with clubbing, sternotomy scar, thrill all over most prominent over the pulmonary, harsh murmur all over most prominent over the pulmonary, I said ejection with regurgitant component CNS: cranial nerves Patient had vertical gaze palsy, checked eye movements twice, after the time was up I realised I should have checked tremor Station 4 Father pneumonia in shock, needs intubation son doesn't want Met all his concerns, (all the same concerns as in previous stations) then the examiner tells me did you inquire about the relationship between the two of them, then bla bla bla Station 5 BCC 1: 55y F, pain in hand and leg Rheumatoid hand, swollen knee, know Hypothyroidism, bibasal creps with dull purcussion, was taking methotrexate for a very long time, met concerns, examiners asked me wether I looked at the thyroid, I said no BCC 2: 54y M, dizziness with blurring vision, no postural drop Known diabetic, recent changes in medication, checked pulse, heart, carotids, examiners asked wether I checked legs neurologically, I said no Station 1: Resp: ILD underlying systemic sclerosis Abd: splenomegaly Station 2: altered bowel for 6 months, young, mevebarin not effective

Patient complaints cramp which relieves after defecating for 9 months, no weigt loss no blood, I said DD IBS, coeliac [29/11/2018, 20:28] +91 98859 99262: Kochi CVS not known what , cardio myopathy CNS hsmn Chest pleural effusion Abdomen minimal ascitus Communication . Sick Patient wants to get home Son wants her to stay History Hereditary angioedema Diet 3 Kochi 2018 Day 2 first round station 2 young female with chief complaint of palpitation. When explored, it s more of exertional dyspnoea. positive h/o child delivery few months ago. some wt loss (+), preferred cold weather, also h/o asthma on salbutamol inhaler prn. taking coffee 3-4 cups per day. h/o IHD in her parents. so her main concern is for heart disease causing palpitations. gave diffreentials ○ः hyperthyroid drug induced anxiety postpartum thyroiditis. forgot to give one important differential the examiner really wanted which is anamia in view of recent delivery history. Station 3 ○ः rt sided hemiplegia likely stroke.. CVS○ः only heard systolic murmur loudest and difficult to differentiate. so gave differentials ○ः MR, TR, VSD, AS Station 4 ○ः a case of elderly female pt with underlying parkinsons GP didnt start any medications for Parkinson before. now admitted funtional decline and UTI,treated with antibiotic. started some Madopar treatment during this admission.

Task was to talk to son and explain pts condition and further Management plan and addressed concerns. the concerns were ○ः son is keen to know ○ः- any possibility of recovery of his mother-any relation with dementia and parkinsons.-why GP didnt start treatment for Parkinson-any role of LPA if his mom develops dementia.- social issues mom is staying only with husband, no other carers, etc. the examiner wanted about advanced care planning in discussion. BCC 1 man with headache and poorly controlled hypertension. the examiner wanted to explore and examine for secondary causes of HTN. missed to ask about symptoms of phaeochromocytoma. gave differentials ○ः endocrine causes. renal causes, etc. BCC 2 a case of ankylosing spondylitis. pt is taking eternacept and sulfasalazine. the examiner asked about possible side effects and precautions regarding these medications during discussion. station 1 COPD with possible bronciectasis (coarse crepts in left lower zone) abdomen ○ः young middle age man clubbing, jaundice,gynaecomastia, splenomegaly gave differentials ○ः chronic liver disease. chronic haemolytic anamia. myeloproliferative disorder. Hope my sharing of cases can help future paces candidates in some extent for learning old questions and practice for paces. Really appreciate and thank to Dr. Rasheed and all the founding members in this groups. Best of luck to all paces candidates.

[24/02, 22:59] Dr. Hamdy paces: Morning carousel- 22/2/2019

S1- ILD, scleroderma S2- 34 yr male-multiple episodes swelling of face, lips.. no family history.. ramipril stopped..on aspirin beta blocker for cad S3- umn rt lower limb weakness Eisenmenger/ tof S4- young hocm- to discuss dx, concerns, S5- 1)pemphigus vulgaris 2)First seizure, ckd on mhd, dm, htn, [24/02, 22:59] Dr. Hamdy paces: Kochi - 23-2-2019 diet 2;Station1 -respi-lady with wheezing and productive cough—d/ d bronchial asthma , Bronchiectasis ,copd; Abdomen- ascites , man d / d -alcoholic liver disease; tuberculosis , viral hepatitis;malignancy Station 2- 26 lady with joint pain, fatigue and hypothyroidism-2 abortion in past; lymphopenia, ? Sle with antiphosphoab syndrome Station 3. - Charcot Marie toot h diseaseCardio- metallic mitral valve replacement Station 4- gbs explanation Patient concern whether it is ms Station 5-bcc 1 rheumatoid arthritis - not controlled with medicines - concern - what next treatment - biologicals Bcc2 - man palpitations and weight loss and breathlessnessH/ salbutamol inhaler - thyroid swelling - toxic thyroid goiter

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2018 St-1○ः Abd- transplant kidney, scar of fistula, another f istula, engorged, no other sign Resp- COPD, Rt upper lobe vocal resonance increased, dd for that. St-2○ः DM, T-2, with a hist of confusion for 3 hours without loss of conc. no focal symptoms. HTN, On, metformin, glucozide, aspirin, losartan, and atorvastatin. Pt also have migraine. It was Transient global amnesia. I gave dd of hypoglycemia, TIA, Elect imbal, Uremia on the background of dm nephropathy. I request the pt

to discont driving while inv are ongoing. but they keep asking if all the normal, what I will suggest. St- 3○ः CVS. MVR, Scar Neuro, rt 7 th LMN palsy with a parotid gland OT scar, examiner asking about cause, why a tell alcohol, last minute I understand that he want to know whether there is any peripheral neuropathy. St- 4○ः Pt of IBS, increase syp of pt due to sons overactivity, all inv are normal, consultant see the report and wants to start amitryptyline. surrogate was too bad, and wants more inv, doesnot want the rx, as her

mother taking it for depression, I tried, but failed to make her convinced. St 5◌ः BCC 1- Rash and joint pain of a pt 37 year, started 10 days back after GP gave antipyretic drug that patient cannot mention. rash has been subsided but joint pain persist, and On examination there is tender PIP and rt ankle swelling. I gave dd of viral arthritis, dengue or chickungunia, Leukaemia, Aplastic anaemia, HSP, Seroneg arthritis etc BCC-2- Tingling and numbness of palm and sole of a 32 yr man, Inside, scar in neck, pt cannot tell why the operation was done, but gave hist of recurrent stone. I forgot to elicit the trousseaous sign what examiner expecting. I gave dd of Hypocalcemia due to parathyroidectomy due to primary hyperPTH

2018 St 2◌ः : Osteoporosis in young Loose stool Wt loss St 3◌ः : Cardio: MR Neuro : cerebellar syndrome Disscussion on MS Station 5◌ः BCC 1 : confusion with respiratory symp. Cough ..haemoptysis and wt loss DD Causes of confusion Bcc2 : diabetic with reduce in vision Fundoscopy =normal Disscussion diabetic eye St 4◌ः : stroke pt Son refused admission Station 1◌ः Resp :ILD Abdomen : CLD 2018 It was a tough exam I gave in kochi 2nd carousal today, 24.02.18. St-1 Abd- transplant kidney, scar of fistula, another f istula, engorged, no other sign Resp- COPD, Rt upper lobe vocal resonance increased, dd for that. St-2- DM, T-2, with a hist of confusion for 3
hours without loss of conc. no focal symptoms. HTN, On, metformin, glucozide, aspirin, losartan, and atorvastatin. Pt also have migraine. It was Transient global amnesia. I gave dd of hypoglycemia, TIA, Elect imbal, Uremia on the background of dm nephropathy. I request the pt to discont driving while inv are ongoing. but they keep asking if all the normal, what I will suggest. St- 3 CVS. MVR, Scar Neuro, rt 7 th LMN palsy with a parotid gland OT scar, examiner asking about cause, why a tell alcohol, last minute I understand that he want to know whether there is any peripheral neuropathy Kochin diet 3 , 2017 Respiratory station-the patient was having breathlessness ,Indrawing of chest, tracheal deviation to the right coarse creps bilaterally but more on the right ..he also had reduced air entry and exploratory wheezes,they asked wat are ur positive findings ,then diagnoses .-I now think it was pulmonary fibrosis with tracheal deviation ..I couldn’t correlate the clinical findings at that time Bec of time limit and the examiners were confusing me more ..I said bronchiectasis Bec of the quality of creps ..I didn’t have the brains to reason that it was an old man ,in India I should be saying pulm fibrosis,but when I said bronchiectasis immediately the examiner asked ok so why do u think it is (for a sec I thought I was right and

I started building it up) then I realised I could be wrong and then it all became disaster ..I got 11/20 abdomen-it was post renal transplant with palpable transplanted kidneys ..this station was good ..they asked Wats the probable cause for this young man ..I said glomerulonepgritis ,autoimmune etc, Got19/20 Cvs was mitral valve replacement ..they asked everything regarding the causes ,warfarin ,prophylaxis,complications ..20/20 Cns Parkinson’s .again asked everything about substantiating the diagnoses ,management , 20/20 Station 5 BCC 1 ; Thyroid eye disease Bcc 2 : Raynaud Alhamdulilla cleared the exam ..but I would say please concentrate on bcc,if u get thyroid be happy unless u know in and out of thyroid👳ame goes with psoriasis,rheumatoid and all .get a partner and keep practicing station five scenarios ..keep telling wat all wel look for.keep seeing cases and examining in the order .. Insha allah u will all pass ...👩 will soon be exiting from this group..I wish all the best for everyone..

2018

Kochi : 23/02/18 Sation 1: Respi: ILD(Systemic sclerosis), Abdomen: Ascites with splenomegaly, Station 2 : 32 year old gentleman having frequent

bowel upset on and off , initially relieved by Antispasmodic but now the frequency of diarrhoea has increased. No history of night sweat, wt loss or fever. Stress aggravates diarrhoea. Dx : IBS. Station 3: Fallots (young man , dyspnoic , clubbing, midline sternotomy scar) , examiner stressed on VSD also as DD. St 4: 72 year old COPD patient got admitted with severe hypercapnoea and managed initially with Antibiotic , steroid and nebuliser and NIV now doing better but still maintaining SpO2 88 to 90 . He has his grand daughter's marriage ceremony after 4 months. He has given permission to talk to her daughter regarding further management. Your consultant asked to motivate daughter that he should not be put on Invasive ventilation as that will not benefit much. BCC1 : Filariasis left leg .BCC 2: Drug induced (Antihypertensive induced hypotension) / Autonomic neuropathy due to diabetes 2018 23rd Kochi Cvs - MR with pul HTN AF CNS - bilateral ptosis with ophthalmoplegia Abd - ascites with suprapubic scar other said transplant kidney, I did not feel any mass 🐠Respi- ILD History- IBS worsening with FH of Ca colon Comm- very long scenario, acute exacerbation of COPD patient with poor prognosis
BCC 1- intermittent fever for 6 months with unilateral LL swelling BCC 2- transient collapse with recent change in dose of antihypertensive , payient is also on Insulin 2018 Kochi 22/2/18 , 2nd carousel St2 : young male with backache with stiffness ,worried about job & life St 4 : female with pckd Abdomen : CLD with portal hypertension Resp: Lobectomy Cardio : Vsd Neuro : spastic paraparesis Bcc1 : treated Psoriasis dark coloured patches..?? Bcc2 : Goitre with palpitation. 2018 24/02/18 Colchi 1st carosel Station 1. COPD with crepts at LLZ, I have Dx of COPD and broncheictasis Another patient rt lobectomy Station 2 DM patient, confusion while she was sitting in restaurant with her friend. H/O of migraine not on treatment. Dx TGA. Examiner wants to know asaociation between mugraine and TGA. Station 3 CVS MR + AS Another case MVR Neuro rt sided facial palsy Station 4 Diagnosis of IBS, to explain patient and to start amitryptline, patient is stressful for her son

diagnosed as hyperactive. Patient concerns are want more test, why stress can cause my symptoms and side effects of amitryptline. Station 5 BCC1 Rash and arthralgia after medications. H/O fever 1 week before symptoms. BCC 2 numbness on hands and feet, scar (+)at neck. H/O renal stone (+) 22nd feb 2nd diet Station 1 Git -chronic of liver ds with portal htn decompensated / hemochromatosis is a possible dd as pt was hyperpigmented Resp -ILD with scleroderma Station 2 : young female with IDA in the background of IBD. Clear history of malabsorption .past history of travel to lakshadweep ..No bleeding manifestation except menorrhagia Could be coliac ds,tropical sprue i guess... Station 3 CVS:Elderly man with atypical chest pain esm in aortic area / high volume pulse / collapsing/ bp was normal /no wide pulse pressure ..not sure wat exact diagnosis is...discussion of case was on As vs aortic sclerosis Cns -both upper limb bilateral lmn signs..severe f laccidity wasting .Power was zero in both limbs .No sensory signs with? fasicualtion(some flickering at infraclavicualr area was there.).... Discussion was on

progressive muscular atrophy and muscle disorder like myotonic dystrophy.. Station 4-angry relative -speak to son whose mother developed steroid induced psychosis after starting steroids for GCA Station 5-Ankylosing spondylitis-Dizziness - she had AS, had thyroid enlargement , orthostatic hypotension and possible drug induced dizziness as she was on multiple drugs for htn Kochi 22/2/18. 2 Nd carousel St1 cld with portal hypertensio Resp:

lobectomy St2 young male with backache with stiffness ,worried abt job Nd life St3:cvs vsd Neuro spastic paraparesis St 4 female with pckd Bcc1 treated psoriasis dark coloured patches..?? Bcc2 goitre with palpitation. Started with stn 1- respiratory was copd, was fine with expected questions on management, abdomen was transplanted kidney, history was young 32-male with loose watery diarrhea with strong family history of malignancy, suspected himself of malignancy-was IBS , told him same, about CBT, but forgot asking travel history--Cns was quite confusing with command being that this man's relatives complaining of some facial abnormality
on appearance there was ptosis .....messed up this and carried it onto other stations as well Cvs- middle aged man with Pectus excavatum , had Mr and ms..... at least appeared so, dd vsd Bcc1--filarial limb(elephantiasis) Bcc2--60yrs male, ihd post cabg on multiple meds ,had syncope Kochin diet 1 Started with bcc Old female with surrogate dizziness Pulse 55 Bp lower dont rember exactly Inside patent had thyroid swelling Drug list atenolol . losartan, aspirin I thought there is esm at aortic area Asked to do postural drop in bp. Examiner gave values there was postural drop History of irregular fast palpitation on drug. Concern was is it heart attack ? Dd that i gave Postursl fall in bap Betablocker. Induced brasycardia Aortic stenosis Asked to do electrolyte to check for addisons Second case AS Station 1 Abdomen splenomegaly was there i couldnt find any other finding. Examiner was asking about hepatomegaly Dd investigations Respiratory. Instructiin wrote copius sputum
Clubbing of fingers and toes Rt basal coarse creps 3- cvs pansystolic murmer CNS muscular dystrophy. Examin upper limbs in middle aged man Some other cabdidates got cld ipf valve replacemnt and hemiplegia 2017 Kochi 15/11/17 3rd Carousel. CVS - Metallic aortic valve Neuro - hemiplegia Resp - right upper zone crepts. ? Consolidation Abdo - Renal transplant History - 29 male, diarrhoea for 6months since returning from Himalaya, chronic sinusitis for 2 yr. Past history of meningitis and knee infection. Communication - talk to son. Father who has dementia, admitted with pneumonia, started on antibiotic. Son not happy and keen on alternative therapy. BCC1 - Long standing RA, taking MTX, Leflunomide, prednisolone for 10yr, ongoing pain. BCC2 - 67 male with palpitation and SOB. Hyperthyroid symptoms with goitre. Past history of asthma on ventolin inhaler. Kochi 16 nov St 1. ILD. St 1 Splenomegaly/ Ascities. Portal hypertensionChronic liver disease St 2 . Young lady with Tiredness. Type 1 DM. In the station . Pt has hypothyroid symptom
hypogonadism Likely APS2 St 3 PSM . I think it is MR Parkinson St 4 Med error. Pt admitted for pneumonia . Has good recovery. Given wrong type of insulin nd hs hypoglycemia St5 Young lady . Tiredness and Short stature. Pt denied every symptom . Apart from tiredness does not have any positive symptom of hypothyroid. Addison or chronic disease. No past med h/o . No family h/0. All family memeber are short. St 5 old man with hand pain Psoriatic arthropathy 2017 Kochi centre last cycle in last day 18/11/2017 St 1 # CLD e splenomegaly+ascites # rt sid lobectomy St 2 Behcet's disease all other candidates say SLE I considered SLE second diagnosis!! St 3 # I think AS murmur supported by the comments written pt has breathlessness e exertion but also written palpitations the examiners concentrate on palpitations more than AS!!! # LL peripheral neuropathy St 4 myotonia dystrophica diagnosis and genetic implantation on family!! Tough imaging examiner!
 St 5 # diabetic retinopathy fundoscope examination # scleroderma e Symptoms of Raynaud’s 2017 Diet 3 , 2017 Station -1 Abdomen - CLD WITH PORTAL HTN RESP- right lobectomy Station - 2 Arthralgia and oral painful ulcer GP refered suspecting RA Station -3 CVS - Aortic stenosis CNS - ?? peripheral neuropathy Station - 4 Myotonia dystrophy- counseling inheritance and concerns of son getting MYOTONIA station - 5 BCC -1. PROGRESSIVE VISUAL LOSS Diabetic retinopathy BCC-2 Scleroderma with ILD Kochi diet

3 ,2017 18/11/2017 Station 1 ? ILD Abdomen- renal transplant Station 2: Firefighter having asthma. Does not want to change his job, smoker. Station 3 MVR Parkinsons

Station 4 Elderly acute confusion, tremor following acute gastroenteritis. Lithium toxicity, nephrogenic diabetes insipidus. Station 5 Graves ophthalmoplegia - blurring of vision Joint pain - Raynauds in SLE Concerns raised : Is it a heart attack ? What is my problem doctor ? Station 5 Case 1 75yr old lady on antihtn presented with intermittent episodes of dizziness Second case 55yr old Mr ninan presented with long history of back pain now worsened . H She had a mng but was not thyrotoxic . She had a murmur in aortic area but no radiation . In sr no carotid bruit . No loc No postural. She was recently started on a new drug name not mentioned after which her symptoms started Carousel 1 Kochi 15 -11-17 Station 2 30 yr old college professor on treatment with antihtn hypolipidemic statin and aspirin. Presented with headache , poor concentration and short term memory loss . He was also bumping into things . But report s no problem with vision. No history suggestive of acromegaly or Endocrine problems. He has 5 yr pack history .headache only positive sign was it was early morning . No warning signs . My DD was icsol brain secondary - probable lung primary. Second dd was a brain primary . Looked like ank spond. But since he had peripheral signs of psoriasis - ank spond like psoriatic arthritis . He was on methotrexate already. So I suggested to start on infliximab History 10 yr back pain worsened 2 yrs . No red flags History rashes on body 6 yrs Yes. I asked him for a brain scan urgent and not to travel as that was one of his concerns.

Station 4: A 28 yr old gentleman teacher by profession recently married no children was evaluated for neck nodes and b symptoms . Is ip . Diagnosis of Hodgkin lymphoma and plan to put on Hickman line and 6 cycles of chemotherapy were conveyed by the consultant . Now nurse has called u to talk to patient who is worried and wanted to talk to consultant . Since he is not there . He wants to talk to u Listen to concerns and answer questions .

Concerns :
1st : I'm blank . I don't remember what exactly the consultant told me.
Please tell me about the whole treatment issue.
2nd concern : can I have children? What are other side effects? As soon as I mentioned Hickman he was worried if others would see the same.

Next concern is whether he can go to school to teach

Examiner questions:
If he refused chemotherapy what would u do?

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My exam centre was in Kochi-Aster Medcity
My examination started from station 2 (History taking):
A young gentleman presented with productive cough having diabetes mellitus on insulin. He has previous history of Bronchial Asthma on steroid inhalers. His cough is difficult to control.

The diagnosis was bronchiectasis possibly the gentleman had cystic fibrosis as he had abdominal pain suggestive of Chronic pancreatitis. Examiners asked about causes of bronchiectasis and whether I have tried to find out aetiological clue like childhood viral infections like measles etc. Did I asked about clinical features of Kartageners syndrome in my history or not (Nasal symptoms e,g. Running nose etc). Then asked about managing patient with Bronchiectasis. I told about rotational antibiotics based on Sputum for C/S, chest physiotherapy and surgery.
Score: 15/20

Station 3
Cardiovascular system:
My case was a middle aged gentle man having chest pain examine the precordium. He had high volume collapsing pulse with normal first and second heart sound and an ejection systolic murmur heard all over the precordium also heard in the axilla (possibly galavardin phenomenon). Also an early diastolic murmur of Aortic regurgitation. I told about AS with AR with predominant lesion being AR. I was asked if the patient has chest pain what I am going do? Management of Aortic regurgitation and criteria for valve replacement.
Score: 20/20

Neurology:
I was asked to examine the lower like of a young person who has difficulty in walking. I asked for " can I ask the patient to walk (as there is difficulty in walking but not unable to walk). But the examiner asked me to it later. I found spastic paraparesis with bilateral planter extensor and bilateral cerebellar sign. The examiner was asking me to clarify about unilateral or bilateral cerebellar sign? Then asked about differentials I told about MS, Spinocerebellar ataxia, stroke (rarely) etc.
Score: 11/20

Station 4
Communication skill:
I was talking with the daughter about a medical error done by injecting intravenous amoxycillin

where as the patients record shows He was allergic to amoxycillin. Which then lead to the collapse of the patient with shock then he had undergone resuscitation and became settle. But the surrogate is not convinced about acknowledgment of medical error and want further action to be taken. I talked about complaint manager and PALS etc. The examiner asked me that your lawyer telling you that don't acknowledge about error done by the team member, what would you do? I told about telling the truth etc. The station didn't actually not what I expected.
Score: 8/16

Station 5
BCC 1:
A middle-aged gentle man having graves disease having block and replacement therapy (Carbimazole and levothyroxine). On examination he is currently in euthyroid state. What can be done about eye problem was the question and signs I looked for assessing the thyroid status. How would i investigate him further?What are the other options of treatment etc.
Score: 25/28
BCC2:
A young female having typical history of migraine e,g. Unilateral headache, photophobia, phonophobia, nausea and occasional vomiting sometimes associated with vertigo. No history suggestive of headache due to raised ICP, No danger signs like no focal sign, planter flexor, fundus normal. But she was taking abortive therapy like paracetamol etc. I offered preventive therapy like propranolol, amitriptyline, topiramate etc.
Score: 28/28

Station 1
Respiratory:
My case was a middle age gentleman having features of COPD as evidenced by supraclavicular excavation, prominent accessory muscles of respiration etc. But there was scar mark on both sides of chest indicative of previous ICT drainage. Initially I thought it

was unilateral pathology as the right sided scar for ICT was more prominent and left side small
scar and trachea was slightly shifted to right (Which is normal). But later examiner was interested in guiding me to come up with bilateral pathology . Then I told about COPD and regarding scar actually dye to previous pneumothorax.
Score: 16/20
Abdomen:
The case was a middle aged gentleman with moderate splenomegaly without any peripheral stigmata of Chronic liver disease. No evidence of anaemia rather conjunctival suffusion. The examiners asked about the differential. I told about myeloproliferative disorder e,g. PRV, Chronic Myeloid Leukaemia and Myelofibrosis. They have asked me about Polycythemia and it's treatment. Discussion regarding blood lating/venesection and drug therapy.

Score: 20/20
Total score: 143/172

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kochi (21.2.2018)
✔️st 4- talk to son of the patient who is in rehab ward c/o headache, no biopsy taken given steroid for GCA .hallucination developes and shift to main hospital. Son is angry because she was shifted without telling him.
✔️st 2-young female with fatigue - 6 months, the IDA, underlying IBS. No bleeding manifestation except menorrhagia, thyroid function is normal..Traveling history - 6 months ago. Clear history of malabsorption Wt loss + 7kg. Family HO type1 DM in brother
✔️St 5- syncope in elderly women with DM. she had AS,palpitations + PR 50/ min. Inside- thyroid enlargement.No hyper/hypothyroid symptoms.she was on multiple drugs for hypertension.
St5-
back pain for 12 years . Nocturnal pain, stiffness, progressive in nature.
Ankylosing spondylitis

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Today exam in India
Station 5
1- Diplopia duo to Thyrotoxicosis
2- Palpitation
***
Kochi ,1st carousel
Station 4 : Diagnosis of IBS, to explain patient and to start amitryptline, patient is stressful for her son diagnosed as hyperactive. Patient concerns are want more test, why stress can cause my symptoms and side effects of amitryptline.
Station 2 : DM patient, confusion while she was sitting in restaurant with her friend. H/O of migraine not on treatment. Dx TGA. Examiner wants to know asaociation between mugraine and TGA.

BCC1 : Rash and arthralgia after medications. H/O fever 1 week before symptoms.

BCC 2 : numbness on hands and feet, scar (+)at neck. H/O renal stone (+)

Station 1 : COPD with crepts at LLZ, I have Dx of COPD and broncheictasis
Another patient rt lobectomy

Station 3 :
CVS MR + AS
Another case MVR

Neuro rt sided facial palsy

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Kochi 15/11/17
3rd Carousel

#CVS - Metallic aortic valve
#Neuro - hemiplegia
#Resp - right upper zone crepts. ? Consolidation
#Abdo - Renal transplant
#History - 29 male, diarrhoea for 6months since returning from Himalaya, chronic sinusitis for 2 yr. Past history of meningitis and knee infection.
#Communication - talk to son. Father who has dementia, admitted with pneumonia, started on antibiotic. Son not happy and keen on alternative

therapy.
#BCC1 - Long standing RA, taking MTX,
Leflunomide, prednisolone for 10yr, ongoing pain.
#BCC2 - 67 male with palpitation and SOB.
Hyperthyroid symptoms with goitre. Past history of
asthma on ventolin inhaler
Kochi 16 November
#St1.
ILD.
Splenomegaly/ Ascities. Portal hypertensionChronic
liver disease
#St2
Young lady with Tiredness. Type 1 DM.
In the station . Pt has hypothyroid symptom
hypogonadism
Likely APS2
#St3
PSM . I think it is MR
Parkinson
#St4
Med error.
Pt admitted for pneumonia . Has good recovery.
Given wrong type of insulin nd hs hypoglycemia
#St5
Young lady . Tiredness and Short stature.
Pt denied every symptom .
Apart from tiredness does not have any positive
symptom of hypothyroid. Addison or chronic disease.
No past med h/o . No family h/0. All family memeber
are short.
St 5 old man with hand pain
Psoriatic arthropathy

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My first attempt (Kochi February 2016) was
underprepared one but surprisingly I scored
very high 153/172 and lost in skill B by 1 mark.
In second attempt (Kolkata Nov 2016) I again
started 2.5month before the exam. I tried hard to
make it through by concentrating on station 5,
but was not confident in clinical stations. I lost
the diet 132/172 , 4 mark short in skill B. While
preparing I applied for the third attempt in
Chennai (April 2017). After the second failure I started rapidly and this time I tried to form a
group, so I was shifted to rented house and
some of my other exam gong friends actively
participated in group discussion and seeing
cases together. This actually helped a lot and I

regained my confidence.
I have noticed in my previous attempts that examiners ask only few questions in clinical stations and they expect a quick systematic answer. I have prepared timed answers (30 -40 sec) for investigations and managements for most of the common cases and practiced it repeatedly with friends, juniors and even mirror. In reality these have made a difference which I felt this time. I did not have to think when I was answering the common questions.
I suggest all fellow comrades to prepare their own notes and rehearsal beforehand so that everything becomes smooth during the exams. For understanding I shall share my notes after few corrections soon.
Lastly, I can surely say that even if it took me 3 attempts to clear PACES, but it enhanced my clinical skill significantly and made me a better doctor. Thanks you all again.
6.4.2017 (1st round) Sundaram
Resp: c/o: SOB
rt lower lobe bronchietasis
Abd: C/O: abd discomfort
AV fistula with hepatomegaly
CVS.. MR: apex beat not displaced heaving, systolic murmur at mitral area
Complaint.. chest pain
CNS: C/O: difficulty in walking examine neurological system
Parkinson
History: chest pain: vauge pain, st worse with meal but cant relieve with antacid. SOB+. Strong family history of ht attack in father and brother. Ex smoker. Hypercholesterolemia +.
Comm: BBN meningococcemia
Bcc: neck swelling.. simple goitre euthyroid
: hypertension, temi pain and hamaturia: PKD. (pt: normal).

******
kochi
st 4- talk to son of the patient who is in rehab ward c/o headache, no biopsy taken given steroid for GCA .hallucination developes and shift to main hospital. Son .is angry because she was shifted without telling him
st.2 - history - patient presents with fatigue - 6 months, the IDA, menorrhagia, thyroid function is normal. underlying IBS. Travelling history - 6 months ago. Wt

loss + 7kg. Family HO type1 DM in brother
st 5 - syncope in elderly women with DM. No DM
retino/ nephro/ neuropathy. palpitations + PR 50/ min.
.Inside - goitre. No hyper/hypothyroid symptoms
st 5- AS back pain for 12 years . Nocturnal pain,
.stiffness, progressive in nature
st 1 - bronchiectasis?? clubbing with crepts
Abd - splenomegaly
st 3- CVS- AVR
Neuro- Stroke
st Feb kochi 21
Station 1
Git -chronic of liver ds with portal htn decompensated
/ hemochromatosis is a possible dd as pt was
hyperpigmented
Resp -ILD with scleroderma

: Station 2
young female with IDA in the background of IBD. Clear
history of malabsorption .past history of travel to
lakshadweep ..No bleeding manifestation except
menorrhagia
...Could be coliac ds,tropical sprue i guess
Station 3
CVS:Elderly man with atypical chest pain
esm in aortic area / high volume pulse / collapsing/ bp
was normal /no wide pulse pressure ..not sure wat
exact diagnosis is...discussion of case was on As vs
aortic sclerosis
Cns -both upper limb bilateral lmn signs..severe
flaccidity wasting .Power was zero in both limbs .No
sensory signs with? fasicualtion(some flickering at
infraclavicualr area was there.).... Discussion was on
progressive muscular atrophy and muscle disorder like
..myotonic dystrophy
Station 4-angry relative -speak to son whose mother
developed steroid induced psychosis after starting
steroids for GCA
Station 5
Ankylosing spondylitisDizziness - she had AS, had thyroid enlargement , -
orthostatic hypotension and possible drug induced
dizziness as she was on multiple drugs for htn
My exam experience in bradford royal infirmary on 27
march 2017
:BCC1
lady comes with tiredness fatigue and sob, with
previous hx of some brain surgery (hypophysectomy
and she was on steroids, levothyroxine and GH) hx

looks like OSAS. It didn't clicked to my mind that she is acromegaly and OSAS is due to acromegaly itself. I gave differential of hypothyroidism and cushing being cause of her OSAS. Exam findings were nil for anything :-(she repeatedly gave me clue why she is sleepless .and i kept on beating about the bush, same as viva
.BCC2: RA with sob and GP mentioned nodules in xray I couldn't find any abnormalities on chest auscultation:-(and gave d/d if rhenatoid lung and they asked about any d/d of pulmonary nodules, i said .neoplastic. Next qs about invx and mx
Deal with annoyed son who is NIK and his mother was admitted yesterday with acute confusional state due to UTI and AKI (brought by ex husband who claims to be taking care for her) son seems to be away and less caring but he was annoyed why his father (who left his mother when she needed) is around and he demanded that his father shouldn't be around and why the son was not called by the hospital. And he semanded that when she will be discharged he doesn't want his father to be around. (Being next of kin he demanded that he has the right to decide about his mother) i inquired about power of attorneyband advance directive which .son said he has no idea and repeated that he is NIK
.Questions were about rights of next of kin
and if son claims that his father is using mother to get financial benefits and he is responsible for her ill health then what should be your stance. Will u ignore it,)where to report it.(I had no idea
In case there is no legal report where you will get guidance (i said hospital legal advisor, examiner asked who else, i said ex husband. He asked who else..then)he told my by himself that GP can be contacted
then he asked if she gets improved then how will u manage the issue. I said if she is proven competent .)upon recovery then she should decide (autonomy
:3
:Cvs ‘‘‘lady with palpitations
Midline sternotomy, audible click with 1st heart sound. Pacemaker scar. I gave MVR and functioning well. Other candidates told there was ejection systolic (-:murmur of aortic which i didn't find
.Questions were typical
.Neuro : examine lower limb of lady who has weakness
Examination showed power 3/5 both lower limbs.
.absent ankle jerks, downgoing plantars
Stocking sensory loss of all modalities. I gave d/d of peripheral sensorimotor neuropathy but examiner was

.interested in spinal causes and spinal level
.Asked me to give specific investigations only
:2
Yrs lady with multiple visits with sob and wheeze, 40 smoker. GP found wheeze at exanination. And no DVT Further hx
Cat at home. Hx of sob at cold exposure. CONCERN : is .it cardiac
No suggestions of cardiac). I gave dd of asthma copd (churg strauss etc. I am still confused whether there .was any trick in case
:1
:Abd
.male with night sweats
HSM with no lymph nodes, gave dd of lymphoproliferative and myeloprolifetive disorders
.viva about invx and management
Respiratory : subtle findings. I found wheeze, examiner was interested in clubbing (though not apparent, he wanted clear answer whether there is clubbing or not.
.Viva about invx and management

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Egypt

2/24

[10/06, 11:24 pm] +971 55 369 4919: Male 40yrs
DM ,uncontrolled , complicated for counselling about compliance and life style modification

Recent admission under vascular for worsening PVD which is not amenable for surgery

He has proteinuria ,Creatinine of 150
Diabetic retinopathy ,neuropathy
[10/06, 11:24 pm] +971 55 369 4919: Lady 80yrs
Advanced CKD ,eGFR 5
Diabetic,Hypertensive, CAD and old stroke with limited mobility

Visited by the predialysis nurse to assess for peritoneal dialysis found that she lives alone ,severe vision problem so labelled as not fit for PD

The best option for her now is hemodialysis but she doesn't like to come out of home and likes to live comfortable without any pain or stress

Task to sit with her grandson who has the power of attorney to discuss with him the management plan and supportive plan of care
[11/06, 12:21 am] +971 55 369 4919: *Egypt 29.5.24* *diet 2*

Abd Hepatomegaly with huge splenomegaly

Cvs Double valve replacement

Chest Lt sided COPD + rt lung fibrosis with apical bronchial breathing

Cns

Lcc1
Acute confusional state 2ry to hyponatremia
Lcc2
PCP infection on top of HIV

Communication1

Esophageal perforation

Communication 2
Dialysis counselling

[10/06, 11:05 pm] +971 55 369 4919: Consultation 1

20yrs old female with Amenorrhea for 3yrs
All vitally within normal

Case of hemolytic anaemia/thalassemia with hemochromatosis
[10/06, 11:05 pm] +971 55 369 4919: Consultation 2

18 yrs old female with Amenorrhea for 6months

All vitals with normal

Case of Anorexia nervosa
[10/06, 11:05 pm] +971 55 369 4919: Cardio
Male
AF,MS
pul.HTN
[10/06, 11:05 pm] +971 55 369 4919: Abdomen
Hepatomegally
No ascites
[10/06, 11:05 pm] +971 55 369 4919: Neuro
Lt.lower limb UMNL lesion

Intact sensation ,corordination

No back scar
Circumduction gait
[10/06, 11:05 pm] +971 55 369 4919: Ches
Obstructive lung disease

[29/05, 4:38 pm] +92 336 7519026: *Egypt 29.5.24* *diet 2*

Abd Hepatomegaly with huge splenomegaly

Cvs Double valve replacement

Chest Lt sided COPD + rt lung fibrosis with apical bronchial breathing

Cns

Lcc1
Acute confusional state 2ry to hyponatremia
Lcc2
PCP infection on top of HIV

Communication1

Esophageal perforation

Communication 2
Dialysis counselling
[31/05, 9:03 am] +92 336 7519026: *2ND DIET 30MAY2024*
● *LCC*: Amenorrhea (2ry heamochromatosis)
● *LCC*: Amenorrhea (anorexia nervosa)
● *COMMUN*: ESRF not fit for either peritoneal or heamodyalsis
● *COMMUN*: Uncontrolled DM
● *Cardio*: AF in HF (some colleague said there MR)
● *Abdomen*: Hepatomegally (some colleague said there is splenomegally as well)
● *Chest*: COPD
● *CNS*: Lt LL Flaccid monoparesis (with hyperreflexia and upgoing planter)
[31/05, 9:03 am] +92 336 7519026: *Diet 2 30.5.24*

Lcc- painful hands, systematic sclerosis with fibrosis

Communication- recurrence of lung cancer , spine mets and lung mets

Communication- typing error with digoxin, old frail lady died, talk to daughter

Abd- spleenomgaly with jaundice

Rs- bronchiectasis

Cvs- AVR + AR

Cns- lmn with asymmetric weakness-

Lcc- neck lump- painful adenoma, euthyroid

28.5.24 egypt diet 2

Comm 1
Pt admitted with progressive HF, EF 10% , afib with eGFR 20% she passed away
Speak to daughter who is angry on mother's death as daughter beleives it was an error regarding
digoxin dose

Comm 2
Young patient , with recurrent uti
He collapsed in a marathon got dehydrated brought to A&E
it was found his renal function deteriorated Counsel for dialysis

Lcc 1

Young pt , 25 yr old , k/c crohns
On sulfazalazine / steroids tapered and has vomiting/ abdominal pain
D/D
Acute gastritis
Pancreatitis
addisonian crisis

Lcc2
Lower back pain 45 yr old , and
Rash
seronegative spondyloarthropathy

Abd hepatospleenomegaly with ascites
CNS spastic paraparesis /sensory level
Chest copd
cvs MVR or DVR
[29/05, 3:45 pm] +92 327 7975723: *Egypt 29.5.24* *diet 2*

Abd Hepatomegaly with huge splenomegaly

Cvs Double valve replacement

Chest Lt sided COPD + rt lung fibrosis with apical bronchial breathing

Cns

Lcc1
Acute confusional state 2ry to hyponatremia
Lcc2
PCP infection on top of HIV

Communication1

Esophageal perforation

Communication 2
Dialysis counselling

27.5.24 egypt diet 2

LCC
ST5 acute pancreatitis.
2ndry Hemochromatosis to thalassemia
Abd:splenomegaly
Chest OLD
Cardio MVR&AVR
Neuro: PSMN

Comm.station:
Case of MND&Aspiration pneumonia, discuss diagnosis &management&PEG tube insertion.

Comm2
2patches in CXR since 6weeks and repeated CXR showed same patches. Px has a history of lumpectomy &chemoradiotherapy 2years ago for breast cancer.

Not happy she wasn't informed about the opacities in earlier admission
[28/05, 9:12 pm] +92 324 0580669: *28.5.24 egypt diet 2*

Comm 1
Pt admitted with progressive HF, EF 10% , afib with eGFR 20% she passed away
Speak to daughter who is angry on mother's death as daughter beleives it was an error regarding
digoxin dose

Comm 2
Young patient , with recurrent uti
He collapsed in a marathon got dehydrated brought to A&E
it was found his renal function deteriorated Counsel for dialysis

Lcc 1
Young pt , 25 yr old , k/c crohns
On sulfazalazine / steroids tapered and has vomiting/ abdominal pain
D/D
Acute gastritis
Pancreatitis
addisonian crisis

Lcc2
Lower back pain 45 yr old , and
Rash
seronegative spondyloarthropathy

Abd hepatospleenomegaly with ascites
CNS spastic paraparesis /sensory level
Chest copd
cvs MVR or DVR

27.5.24 egypt diet 2

LCC

ST5 acute pancreatitis.
2ndry Hemochromatosis to thalassemia
Abd:splenomegaly
Chest OLD
Cardio MVR&AVR
Neuro: PSMN

Comm.station:
Case of MND&Aspiration pneumonia, discuss diagnosis &management&PEG tube insertion.

Comm2
2patches in CXR since 6weeks and repeated CXR showed same patches. Px has a history of lumpectomy &chemoradiotherapy 2years ago for breast cancer.

Not happy she wasn't informed about the opacities in earlier admission

27th MAY:

LCC
1. acute pancreatitis.
2. Secondary Hemochromatosis to thalassemia
Abd:splenomegaly
Chest ILD
Cardio MVR & AVR
Neuro: PSMN

Comm:
1. Case of MND & Aspiration pneumonia, discuss diagnosis & management & PEG tube insertion.

2. 2 patches in CXR since 6 weeks and repeated CXR showed the same patches. Px has a history of lumpectomy & chemoradiotherapy 2 years ago for breast cancer.

Not happy she wasn't informed about the opacities in earlier admission

1/24
Today my paces exam in cairo
Maadi centre

Station 1
Resp COPD +_fibrosis

Medical error

Station. 2
AIP

station 3
Cardio :aortic and mitral valve replacement
Neuro: hand exam. ulnar and median nerve injury

Station 4
Abdomen HSM and ascites

Breaking bad news: APKD.

STATION 5
Psoriatic arthritis

****
Neuro: spastic paraperesis with cerebellar signs

Cardio: MS with AF

Resp: Right sided collapse

Abd: Young boy with deep jaundice, splenomegaly, tattoo & transverse scar on abdomen

Com 1: DNAR (Ca breast with mets)

Com 2: error (missed anti epileptic drug during stay in hospital)

LCC 1: weight loss, diarrhoea (Grave's disease with AF)

LCC 2: SOB (ILD due to RA)

Puducherry 3rd Carousel :
Lcc 1 - Rash v
: Psoriatic arthropathy

Lcc 2 - Chest pain - ACS with metabolic syndrome

cardio - MS with CMC scar

Neuro - Spastic Paraplegia

Abdomen - Alcoholic CLD, Dupuytran Contructure

Respi - inf ex of COPD

comm 1 : hypoglycemic unawareness

Comm 2 : TIA, af. Counselling for anticoagulant
Today's Puducherry

Lcc

1.vitiligo with addison

2.Dm with empa uti/pyelonephritis

Comm

Aspirin s/e, concern is Allergy
Mtx induce pneumonitis,

Cardio :TOF(vsd,ps)

Neuro :MND or motor neuropathy (command on UL, all r LMNL

Abdomen : CLD (huge ascitis) lots of stigmata

Respi : Left thoracotomy scar
But bL feature of bronch
Trache not sure
I believe these are the cases 3 rd day ; 3rd carousel pondichery

CVS : AS with AR
CNS: umn lesion asked only motor , location of the lesion: spinal cord .

RS: lobectomy underlying BRONCHIECTASIS
Abd : HSP with jaundice hemolytic anemia with open
chole scar

LCC: thyrotoxicosis,
LCC 2 : known case of Mg, suddenly developed difficulty to swallow and speech , Mg crisis vs Cholinergic crisis .

Communication: error , PD staff nurse not given one dose , IR , apologies,

Communication: admitted pt ,had black heel ulcer developed, 2 days . Apologies, IR,

****
30/1 Cairo
Neuro ALS
Cardio MS+P HTN
Chest Obstructive lung disease
Abdomen Hepatosplenomegaly

Communication: Myotonic dystrophy
2nd one patient for urgent CAG +/- CABG

Clinical consultation :
1. bilharziasis complicated by melena
2.Other one insulinoma

****----

3/23

Station 2:
Young female , presented with 6 months hx of SOB and urinary frequency
Recently diagnosed with DM and HTN which are difficult to control ..

Cushing syndrome

Station 3:
Neuro: flaccid paraparesis , with impaired sensation T8 , patient was catheterised and has jugular line , symptoms duration was 1 month

Cardio: AVR with murmur over the aortic area.
discussion was about the causes of murmur on replaced valve

Station 5:
55 years old lady C/O: SOB ,investigations showed microcytic anaemia.

BG: double valve replacement on warfarin

Station 4:
Consultation: speaking to the wife, whose husband presented to the A&E 2 weeks ago with a few weeks history of worsening SOB and chest tightness. He was reviewed by a junior doctor, SPO2 and ECG were normal. CT chest without contrast showed fibrosis and asbestos plaques. He was working in the asbestos industry. Few days later he died, post mortem revealed multiple PEs.

Abdomen: hepatosplenomegaly

Station 1:
Consultation: MND , prognosis:months, now on modified diet as recommended by SALT, discuss with him the possibility of future need for PEG/RIG and NIV to inprove the quality of life

Chest:COPD

Diet 2 2023 egypt

St 5 : pheochromocytoma. came with palpitation. In examination, ask to examine funds.

2nd case : CML . came with bleeding. Examination - huge spleen.

St2 chest pain dd gerd angina

Chest COPD
abdomen thalassemia
Neuro stroke?
Cardio mvr pH

Communication suicidal attempt nurse take hypoglycemic medication

Cairo University Hospital Center

Station 2
Male patient with paraplegia due to malignant spinal cord compression.

Station 5
Behcet with LL DVT.

Diabetes Insipidus

St 1
Chest
Left sided lobectomy in patient with bronchiectasis

Abdomen
Hepatosplenomegaly with CLD signs

St 3
Cardio
AS with lung crackles

Neuro
Spastic Paraparesis due to MS

St 4
Explaining drug reaction (Aspirin)

Egypt early this year.

Station 1 :
Chest : left side move less, trachea deviated to left side, decreased air entry, stony dull percussion note almost all left side bronchial breathing in left upper part patient is cachexic seem they want Pleural effusion as main diagnosis

TB as Differential

Abdomen : HSM and Anemia they want CHA ie thalassemia

Station 2
Back pain :

55 years old female

ALP high, corrected calcium lower normal

Backache for 6 months, suddenly worsened 2 months back(mechanical)
No red flags otherwise..

has history of celiac disease Hx of premature menopause, smoker.
D : Osteoporotic fracture

Station 3:
CVS :
On wall paper SOB, PR : 110, Temp :38
Osler nodes
PHTN and loud S2
aortic Stenosis
Infective endocarditis

Neuro :
Left LL UML hypertonia, hyperreflexia, Clonus, Flexor weaker than abductor. Could not assess the sensation.
I mentioned Hemiplegia he asked where is the side of the lesion I told I want to examine cranial nerve.

Station 4 :
Probably lung cancer patient, heavy smoking since 11 years of age, has unseatiness, falling and fractured his left humerus. CT brain showed mets to the left cerebellum.

Task is to explain the need for CT chest and Bronchoscopy and Biopsy.

Station 5 :
BCC 1 : Addison's
BCC 2 : patient has weight loss and poor appetite.

History of armpit lump but no lymph nodes during examination He looks cachexic has Splenomegaly but I can't find hepatomegaly some people till that he has hepatomegaly
diagnosis is Lymphoma vs Myeloproliferative disorder

CVS
I think double valve replacement

Examiner ask what is the ix - then mention all blood and echo, then he ask if echo what u want to see
Then if echo can't see what other thg to do, I mention cinefluoroscopy.

Respi
Patient is short stature with wheelchair and walking aid, no clubbing, no cyanosis, not in oxygen
Right upper and middle lobe collapsed with tracheal deviation to right bronchial breathing and short stature and crepts at left chg with coughing
Some said gt vp shunt I didn't notice (duno will be penalised or not)
I saw a scar at the abdomen initially I suspect is it previous peg tube
I said cystic fibrosis then examiner discuss along that and ask most common organisms - how to treat
(This one alot of us not sure what is the diagnosis also)

Neuro
I think MND but not sure correct or not
Sensation intact propioception intact muscle wasting and reduced power at distal muscle
I saw gt tongue fasciculation
Examiner asked ddx I said multifocal motor neuropathy they not happy
Then they ask how to ix mnd, I mention EMG - fibrillation and NCS to see axonal or demyelinations condition.
Didn't manage to reach mx
(Other people said might be Cidp)

Abdomen
Esrf with Adpkd (patient has acromegaly features - but I didn't mention it)
Examiner ask till management but in the end gt ask if patient has no family history what other thg can related to pkd - this one I can't answer and times up (I think may be they want to hear acromegaly?)

Bcc 1
presented with hand joints pain for 4/12, with stiffness at PIPJ and only three joints involve in one hand (oligoarthritis), then ask further gt a big scaly plaque in the shin there Underlying skin problem (psoriasis for past 2 years)
On mtx, pcm, diclofenac, some cream, compliant, started for 4/12
No sob, no reduced effort tolerance
Lungs clear
No rashes on the scalp or ear

Dx: Psoriatic arthropathy

Concern:
What is the causes of my liver function deranged?

Is this curable?

Examiner question: what is the causes of hepatotoxicity

- I said mtx induced, or related to fatty liver

If mtx wanna stop what will happen? psoriasis flare

What you want to give to replace mtx? I said biologic

Bcc2
Worsening crcl after liver transplant (liver transplant due to liver cirrhosis' secondary to hepatitis c)
Pretransplant kidney creatinine 135, currently one year post transplant creatinine 165
Underlying Dm Hba1c 6.8%, also has frothy urine ufeme 3+ protein, no other dm complications
Compliant to meds on insulin, losartan, tacrolimus
Not on other meds
On regular follow up
No smbg at home
No bp check at home
No uraemia sx
No uti/no hematuria/abdominal pain

Ddx: drug induced or underlying dm nephropathy

Examiner ask what is the ddx, how to manage, if patient didn't check glucose at home what u advice, in ultrasound kidney what else wan to see besides obstructive uropathy if kidney size slightly reduced, times up already I duno what she wants

History
Patient is surrogate

Stem: sudden loss of blurring of vision at right eye this morning - painless, black out, mild headache, no icp signs, no weakness, history of similar episode at left eye few months ago lasted one hour and self resolved didn't seek treatment
Underlying dm/hpn/dyslipidemia not on follow up long time due to busy schedule, on self purchase meds from pharmacist metformin, simvastatin, amlodipine
Chronic smoker but non alcoholic

Diagnosis:
Tia secondary to dm/htn/dyslipidemia defaulted

Ddx: retinal haemorrhage/vitreous haemorrhage

examiner ask me what is pathophysio of Tia

Ix: fbc, rp, flp, Hba1c, ct brain, ecg, echo

Mx: admit, check vital signs and sugar level, patient education, counselling on compliant and follow up
Optimise medications for the comorbid

Refer eye, refer endocrine, refer neuro

Comms skills
Medication errors

86 years old dementia with DM, admitted for Respiratory tract infection, treated well
Dm on mixtard 15 bd, controlled well for 2 years in nursing home Then admitted ward has one episode of hypoglycaemia (after 2 days of admission), only found out the meds is indented as humalog lispro 15 bd

Daughter unhappy
Explain to her and address her concern

UM PACES 01/12/22

Red carousel, AM session

Station 1
-Respi : Right lung collapse consolidation
-Abd : ESRF with B/L PCKD

Station 2
- 45 year old gentleman complain of sudden painless loss of vision , underlying DM
- differentials: Stroke/TIA, vitreous hemorrhage/CRVO etc
- Discussion on stroke

Station 3
-CVS : DVR , well functioning
-Neuro upper limbs: B/L Symmetrical sensorimotor polyneuropathy

Station 4
-explain medication error to patients daughter

BCC
a) stem: middle aged lady with hand joint pain
- Dx : Psoriatic arthropathy

b) stem: middle aged gentleman with liver transplant presents with worsening renal function , UFEME protein 3+
- Diagnosis: AKI/CKD with nephrotic syndrome , possible due to Hep B/DM/ ? Tacrolimus

Muskat

St 5
25 years old female medical student has fever on and off since 1 wk ,sore throat. Lt leg swelling tiredness. Given Amoxicillin for 5 days at the 5th day started maculopapular skin rash allover the body ....

All hx are negative including travel ,hiv. No B symptoms
On examination: there was ln+ splenomegaly

Examiner want IMN

St4 missed sigmoid cancer

Young man with controlled htn since 6 months despite 3 anti htn medication
Looks cushing in exam
But all hx are -ve
All family members have obesity

The other hand pain with pip and mcp and cts
Stiffness more than 1 hr
So RA

Neuro was chorea

CVS was MVR
[
Abd was renal transplant

H/O chronic fatigue weight gain unintentional.postpartum h"ge .depression. hypothyroid features.

St 3 : MR AF, Peripheral motor neuropathy

1st round Comm- man with GTC seizure missed drug binge drinker at weekend packer at a factory lives alone. tasks importance of seizure control. uncontrolled seizures effect.

Station 2-63 old lady complaining of headache..more in the morning..
Past history of Stoke and weakness..
Viva on SOL.

CVS-MR
CNS Spastic paraparesis with normal sensation..viva on multiple sclerosis.

Station 4.,,Diabetic elderly patient age 80,having hearing issue ,secretary call for telephonic consultation.
Talk with his daughter. Daughter told me that no telephone call was received.
She wants to take live consultation instead of telephonic one.

Station 5.
1.Bell's palsy
2.Vitiligo.

Station 1.

Chronic hemolytic anaemia.
COPD

Amman, Jordan

2/24

******
[28/05, 10:41 am] +92 327 7975723: 27th MAY:

LCC
ST5 acute pancreatitis.
2ndry Hemochromatosis to thalassemia
Abd:splenomegaly
Chest OLD
Cardio MVR&AVR
Neuro: PSMN

Comm.station:
Case of MND&Aspiration pneumonia, discuss diagnosis &management&PEG tube insertion.

Comm2
2patches in CXR since 6weeks and repeated CXR showed same patches. Px has a history of lumpectomy &chemoradiotherapy 2years ago for breast cancer.

Not happy she wasn't informed about the opacities in earlier admission
[28/05, 10:45 am] +92 327 7975723: Jordan (Amman) 23rd May*

Lcc 1
Hypothyroidism dx before 2 weeks and started thyroxine
Came with dizziness and vomiting
Hx of skin pigmentation
Addison , APGS

Lcc
I don't know what the case
Female known case of Hypothyroidism and htn
She has neck and elbow rash, but no rash on physical examination,
Complain of chest pain 3 months back with exertion and sob,hx of ugib 3 years back
Father died when he is young with heart attack, and he had a skin rash ???

Communication:
28 yo with htn all test were normal , he is healthy and a smoker
Asymptomatic , advice explained to him to start medication and to do kidney ultrasound to check the size and blood flow

2.Talk to daughter. Her father undergone second Ballon dilatation for achalasia cardia and complicated by perforation, she doesn't want her father know about it and want to discharge him

Abdomen
APKD, AVF in left arm

neuro ?? I don't know if it is cervical myelopthy or MS

Chest : Rt lobotomy with wheeze and crepitations on left side

Cardio: may be AS or MS

****
[*Amman today 24.5.24*

Lcc 1
Hypothyroidism dx before 2 weeks and started thyroxine
Came with dizziness and vomiting
Hx of skin pigmentation
Addison

Lcc
I don't know what the case
Female kn of Hypothyroidism and htn
She has neck and elbow rash, but I did not see rash ,
Complin of chest pain 3 months back with exertion and sob ,hx of ugib 3 years back
Father died when he is young of a heart attack, and he had a skin rash ???

Communication:
28 yo with htn all test was normal , he is healthy and a smoker
Asymptomatic , advice explained to him to start medication and to do kidney us to check the size and blood flow

2.Talk to daughter, her father did second Ballon dilatation for achalasia , and complicated by perforation , she doesn't want her father know about it and want to discharge him

Abdominal
APKD, AVF in left arm

neuro ?? I don't know if it is cervical myelopthy or ms

Chest : rt lobotomy with wheeze and cripitation in lt side

Cardio pt came for checkup only : I listened to apex beat on the right side. No one heard s1 in the lt side, but they said may be AS or MS
[27/05, 12:59 pm] +968 9493 5674: Comm 2 ...
Copd with very sick. Unconscious. Son agreed DNR.

Now better fully conscious. To tell her about dnr decision to continue or not. Refusing ABG also. To explain her the importance of ABG

Amman 23.5.24

Lcc 1
Hypothyroidism dx before 2 weeks and started thyroxine
Came with dizziness and vomiting
Hx of skin pigmentation
Addison

Lcc
I don't know what the case
Female kn of Hypothyroidism and htn
She has neck and elbow rash, but I did not see rash ,
Complin of chest pain 3 months back with exertion and sob ,hx of ugib 3 years back
Father died when he is young of a heart attack, and he had a skin rash ???

Communication:
28 yo with htn all test was normal , he is healthy and a smoker
Asymptomatic , advice explained to him to start medication and to do kidney us to check the size and blood flow

2.Talk to daughter, her father did second Ballon dilatation for achalasia , and complicated by perforation , she doesn't want her father know about it and want to discharge him

Abdominal
APKD, AVF in left arm

neuro ?? I don't know if it is cervical myelopthy or ms

Chest : rt lobotomy with wheeze and cripitation in lt side

Cardio pt came for checkup only : I listened to apex beat on the right side. No one heard s1 in the lt side, but they said may be AS or MS.

****
Jordan (Amman) 23rd May

Lcc 1
Hypothyroidism dx before 2 weeks and started thyroxine
Came with dizziness and vomiting
Hx of skin pigmentation
Addison , APGS

Lcc
I don't know what the case
Female known case of Hypothyroidism and htn

She has neck and elbow rash, but no rash on physical examination,
Complain of chest pain 3 months back with exertion and sob,hx of ugib 3 years back
Father died when he is young with heart attack, and he had a skin rash ???

Communication:
28 yo with htn all test were normal , he is healthy and a smoker
Asymptomatic , advice explained to him to start medication and to do kidney ultrasound to check the size and blood flow

2.Talk to daughter. Her father undergone second Ballon dilatation for achalasia cardia and complicated by perforation, she doesn't want her father know about it and want to discharge him

Abdomen
APKD, AVF in left arm

neuro ?? I don't know if it is cervical myelopthy or MS

Chest : Rt lobotomy with wheeze and crepitations on left side

Cardio: may be AS or MS.

3/23

AMMAN JORDAN DIET 3🎯✍️

Communication
1) Postponed OGD
2) Latent Tb in RA patient before starting biological Rx

CC
1) HF, Dm, Hypothyroidism presented with acute decompensated HF, and Gout of the big toe
2) Chushingoid, has OSA with cor pulmonale

Clinical
AVR
Parkinson
Lobectomy
Liver transplant

Diet 2/23

St 2 PMR
st 4: IBS & AMITRIPTYLINE

ST 5 ACROMEGALY
ST5 PSORIASIS

St1 TENDER LIVER SPLEEN. BRONCHIAL ASTHMA,

ST3 MR TR

NEURO STROKE DD MS.

They provided lead in St 1 m 3 which I capitalised. St5 I picked up dx early. Finished within 7 mins.

St 4 concerns were a bi difficult for me. I tried my best. St 2 i did well.

Kolkata

1/24
****
Day1 (Kolkata)
Carousel 1

St5
Metabolic syndrome

St1
Resp :Ild with RA
Comm:Brain tumour MRI counselling

St2
Bilateral bronchiectasis with euthyroid goitre

St3
Cardio:MVR
Neuro: left sided stroke

St4
Gliclazide overdose (nurse) DAMA
Abdomen: CLD

*****
Diet 1,2024
KOLKATTA Communication 1- explain sle diagnosis and convince for renal biopsy
Communication 2- medical error, giving wrong dose of insulin at hospital while admitted for pneumonia
Abd - hepatosplenomegaly with pallor, jaundice, muscle wasting
Respi - ILD in S.Sc
CVS- MR
CNS - very tricky, examine cranial nerve and diagnosis of INO

BCC1 - headache in a 31 yr old patient with LOC. travel history .
gave dd of SAH and meningitis (no fever) - dummy patient but found some blurring optic disc. (tricky as i know dummy patient but not confident about ophthalmoscope finding - when i said i would do fundoscopy. examiner immediate asked to switch off light probably pupil was dilated)

BCC2 - headache with tinnitus. med history of a.neuroma (i was lucky somehow i read weber and rinne test just night prior to exam)

******
Kolkata 1st day
3rd carousel

CVS :MS
Neuro :INO + Left Sided cerebellar sign
Abdomen :Left Hypochondrium Mass
Respiratory :SS e?? Lung fibrosis.
Findings not clear.

LCC
Headache + blurry vision.
Dummy case.

LCC
Headache plus tinnitus
In a NF patient.

[*******
Kolkata Day -1 (05.04.24)

respi - ILD
cardio - MVR with AF
Neuro - Hemiparesis
Abdomen - Hepatomegaly with ascites

Lcc 1 : bronchiectasis (CF/post TB)
Lcc 2 : Metabolics Syndrome (NASH)

Comm 1 : Gliclazide overdose, DAMA
Comm 2 : BBN of ICSOL, MRI

****
: *Kolkata 6.04.2024*
2nd day 1st carousel

Station 1
Abdomen - hepatosplenomegaly with anaemia and leukonychia

Station 2
SOB plus cough for 3 months
Hypersensitivity pneumonitis

Station 3
Cardio - ASD with polydactyly with pulmonary HTN with clubbing

Neuro - Spastic paraperesis with intact sensory

Station 4
Respiratory - RA with ILD with Cushingoid appearance plus skin thinning with cellulitis with bruise mark

Station 5
50 year old man comes to you with SOB and cough and occasional headache (patient has pacemaker in situ)

Dx - SVCO due to pacemaker wire thrombosis/Bronchial malignancy

Communication:
1. Pt admitted with CAP, improving on antibiotics. PD drug missed, found after 3 days by his wife as he has difficulty in speech and movement. Talk to his daughter now.

2. Known epilepsy, controlled on medication. 1 wk back admitted on orthopaedics, they discharged with tramadol. Last night he had a prolonged episode of seizure. Pt drives, gained his licence after 10 yrs, now again advised not to drive until DVLA makes a decision. He heard from the pharmacist that tramadol was the reason.

Concerns:
Now he wants compensation.
What about his driving licence?
When can he be discharged?

******
Station 1
Communication
A young man being investigated for infections mononucleosis. CMV, EBV were pending but HIV was positive. The repeat test showed HIV was negative. His blood was mislabeled with another patient who has HIV. The consultant had filed incident report.
Task is to negotiate with patients and make joint decision regarding third HIV test.

Communication 2
A young woman with tooth ache was prescribed PCM and antibiotics. However she was using only PCM and PCM instead of antibiotics.
Her PCM level was just above normal.
She she's had 2 IV infusion of N-acetlyceisteine and currently on the third dose that will take up to 10 hrs. However she wants to go home.
Task is to explain to her why she should stay. Treatment options?
Concerns she wants to carry her son's out to cinema for his birthday. She promised him.
What could happen if she didn't complete her treatment since she's not symptomatic?
If the worst happened, what her the treatment options? Will she go home after the third dose?

Consultation 2
37 year old woman
Irregular menses

She has obvious proptosis and neck mass. Diarrhoea, palpitations.
Tachycardia, proptosis, lid-lad, diffuse neck mass.
Concerns

- will she be pregnant?
- will the proptosis return to normal?

Leg swelling in a 70 year old woman
She has DM, HTN, HIV on HAART, GLUCOPHAGE, AND ANTI-HYPERTENSIVE
We didn't really discuss differential but I said she may have vasculitis.
She also had lipodystrophy of her upper limb. Because of fatigue, weight loss and joint pain
***
[07/04, 1:33 pm] +880 1745-845038: Kolkata
3rd day 1st carousel

Cardio - AR
Neuro - Spastic paraperesis with sensory intact with scar in back

Abdomen - Abdomen normal (patient have midline sternotomy scar with epigastric extension with features of Heart failure)

Communication - DNACPR

Respiratory - Obstructive airway disease (COPD)

Communication - Paracetamol poisoning

LCC - Bloody diarrhoea for 3 months (IBD/Abdominal TB/Malignancy)

LCC - Dysphagia for 3 months (RA with SS overlap)

D/D:
Parasagittal meningioma
Tropical spastic paraperesis
MND,bilateral stroke (if old age plus wasting)
and also I want to exclude trauma,tumour,tb.

****
Kolkata 7/4/24 *3rd carousel*
Cardio - MVR with AF.
Neuro - rt.homonymus hemianopia
Abd. - renal transplant, fistula is not working.on abd. Bruises mostly due to insulin injections.
Respiratory - ILD with rheumatoid arthritis, with bruises,ulcer on the leg.
LCC 1 - post mi ptca, with rt. Sided chest pain.
Diagnosis - post herpes neuralgia.

LCC 2- h/o diarrhoea with blood and mucus.
H/o travel, her husband also had diarrhoea but resolved within 24 hours. She had a previous h/o loose stools with blood on & off since 3 yrs, and back pain.

Diagnosis UC / Crohns / infectious diarrhoea.

Communication - pt. Have Parkinson since 12 yrs, 2 yrs dementia. Repeated aspirations pneumonia, not recognising relatives, in nursing home care. Able to sit in a wheelchair with help.

Discuss regarding feeding with his nephew.

Consultant adv. Not to do any invasive procedure. Comfort feeding.

Communication 2- bbn to 24 yrs/F - ADPKD.Her father has ADPKD, on dialysis, going to get married.

[********
Kolkata 2nd day 3rd carousel

Respi - ILD with iatrogenic cushing, RA
cardio - MVR with AF
neuro - Homonymous Hemianopia
Abdomen - Hepatomegaly with jaundice with scar mark

Lcc 1 : TIA / collapse due to AS
Lcc 2 : Epilepsy aggravated by alcohol & stress

comm 1 : counselling for CABG
comm 2 : bbn of amiodarone induced lung fibrosis

_**
Kolkata
3rd day 3rd carousel
07.04.2024

Cardio - MVR with absent pulse in left hand with AF in right hand

Neuro - Right sided homonymous hemianopia

Abdomen - Renal transplant with features of fluid overload

Communication - ADPKD

Respiratory - RA with ILD with teniasis

LCC - Bloody diarrhoea for 2 months (Infective/Ulcerative colitis/Bowel Malignancy)

LCC - chest pain for six weeks (History of PCI - stent thrombosis/ herpes zoster shingles/ MI)

****
Communication

1. Advanced Parkinson's enteral feeding. Recurrent pneumonia. Consultant not keen on invasive procedures.
2. Daughter newly diagnosed with polycystic kidney disease, normal renal function, father has adpkd and is dialysis dependent. Daughter wants to marry in 3 months. She also has a brother

CVS - MVR
RS - Rheumatoid arthritis with fibrosis
PA - renal transplant - pkd
Cns - right homonymous hemianopia

Long case
1. Bloody diarrhoea with back pain and recent history of travel
2. Recent PCI for an MI, with right sided pleuritic chest pain. Patient also has herpes zoster lesions on that side.

******
Kolkata 2nd day 3rd carousel

Respi - ILD with iatrogenic cushing, RA
cardio - MVR with AF
neuro - Homonymous Hemianopia
Abdomen - Hepatomegaly with jaundice with scar mark

Lcc 1 : TIA / collapse due to AS
Lcc 2 : Epilepsy aggravated by alcohol & stress

comm 1 : counselling for CABG

comm 2 : bbn of amiodarone induced lung fibrosis

****

3/23
*****
25.11.23
LCC-
1. Thyromegaly with euthyroid status.
2.Meralgia paresthetica

Cardi- MVR
Resp- RA + ILD
Abd- HSM + jaundice
Neuro- 6th n palsy with possible MS.

Communication- latent TB, lamotrigine.]
****

St 2: LCC- Meralgia paresthetica, DM, Xanthelesma

St 3 :
Neuro : Lt INO, left cerebellar, left UMN facial nerve palsy. (MS)

CVS : MVR

St 4:
Communication : RA, Patients on MTX, planning for biologics, latent TB, IGRA +.

abdomen : hepatosplenomegaly, anaemia, jaundice (HHA)

ST 5: LCC- neck swelling : thyroid nodule

St 1 :
Communication : Epilepsy on lamotrigine, infertility, want to stop lamotrigine.

Respiratory : ILD + RA hand

****
Kolkata case 24/11/23

Station 2

25 yrs female multiple joint pain and wt. loss.
Inside : systemic sclerosis, RA with deformity, Had SOB.

Concern : Why weight loss? Anything can be done for wt. loss?

Station 3

CVS: MVR with absent radial pulse in left hand

Neuro : Spastic paraparesis, Knee exagerrated, ankles absent/diminished, plantar extensor, hypertonia, sensory intact

Station 4

Communication : 39 years male blurring of vision, initially diagnosed stroke, neuroradiologist later confirmed Brain Cancer which is operable. BBN and explain

Abdomen : Hepatosplenomegaly, lymphadenopathy, anaemia

Station 5

35 years male diarrhea with wt. loss
Thyrotoxicosis

Station 1

Communication :

80 years female got LMWH for suspected pulmonary embolism. Initial CTPA reported by radiology registrar, later Neuroradiologist reported artefact. Patient has abd. aortic aneurysm, on conservative management. Talk to daughter and explain

Resp. : Left thoracotomy scar with diminished BS, vocal resonance, dull percussion left lower, trachea shifted to left,clubbing

******
todays kolkata case
Station 2 LCC
32 year female comes with vision problem and 2 days headache - right sided homonymous hemianopia

Station 3
CVS - AR
Neuro - examine motor system - finding left sided hemiplegia

Station 4
Communication- Viral encephalitis counsel about LP
Abdomen - hepato splenomegaly with anemia and jaundice along with spider and temporalis wasting

Station 5
48 year old woman comes with per rectal bleeding
DD - CA colon , IBD , hemorrhoid, anal fissure and ibuprofen induced

Station 1
Communication BBN Mother dying talk to son about DNACPR
Respiratory - RA with ILD

******
kolkata, 1/23
Abdomen - Haemolytic anaemia
Neuro- Spastic paraplegia without sensory loss
Cardio- ASD

Consultation -
Meralgia paresthetica

Episodic anxiety

******

23/ Diet 1,kolkata, India

Station 1 Hepatosplenomegaly with jaundice

RA with fibrosis

Station 2 back pain with stiffness

Station 3 spastic paraparesis with normal sensation

TR?

Station 4 COVID infection in a transplant patients

Station 5

Empa induced cystitis

VSD with gout

St1.
ILD(Rheumatoid arthritis)

ADPKD(I m confused)

2.HIV neuropathy (DD-syphilis,)

St3.
Rt 6th nerve palsy.

ASD with Eissenmenger (Holt arum syndrome) extra finger, clubbing, polycythemia)

4.TB, want to visit her mother in UK.Was not bad

St5.

ILD (AS)

SVCO (with a pacemaker)

******
My case
resp: ILD
Abdomen : ? rooftop scar

History sheehan syndrome

Cardio ASD/ PS

Neuro spastic parapersis with no sensory

Communication : talking with angry son over missed online consultation

Bcc1 pheochromocytoma / hyperthyroidism

Bcc2 meralgia paresthetica

*****

diet 3/22

Respi -Fibrosis with RA
Abdo- Hepatosplenomegaly jaundice

Cardio MV replacement with metallic click with MS

Neuro - Hemianopia with optic neuritis

St5 Vsd with gout
Ank spond sob

St2 Chest tightness in known cases of anxiety with glycosuria and erratic rise BP.

St4 Meningococcal meningitis counselling

[14/02, 3:04 am]:

St 4 medical error with lumbar puncture and rivaroxaban given

St 5 bcc 1
RA with hand numbness CTS

Bcc 2
Thyroid swelling
Goitre

St 1
Resp copd with collapsed upper lobe
Abdomen : transplanted kidney

St 2 celiac disease hx

St 3
Cardio Metal valve replacement(it was avr) i was confused
Cns common peroneal nerve with charcot joint.

Kolkata

CVS VSD
Abdomen. normal

Respiratory : Interstitial LD with SS

Neuro Spastic paraparesis

st 2 Low back pain

St 4 Asthma pt (steroid inhaler)

BCC:

1.per rectal bleeding

2.DM with Meralgia Paresthetica

******
passed from Kolkata Centre, 21st April, second carousel ?

✔ Station.2
🔻
👉 - Analgesic misuse HA with underlying
migraine + family problem.

✔ Station.4
🔻
👉 – Hepatic encephalopathy, alcoholic,
developed hepato-renal $. Consultant decided not to do the transplant.

Talk to son about this and also discuss resuscitation status.

✔ BCC 1
🔻
👉 – Young man c/o joint pain. Has congenital
heart disease. Gout precipitated by diuretics.

✔ BCC 2

🔻

👉 – c/o SOB. Inside : ankylosing spondylitis.

✔ CVS

🔻

👉 - c/o SOB. Mitral valve replacement.

✔ CNS

🔻

👉 - c/o difficulty in walking.
Lt sided hemiplegia + Lt. facial palsy.

✔ Resp

🔻

👉 – Rheumatoid lung

✔ Abdomen

🔻

👉 – jaundice with ascites.

★★★★★

KOLKATA BCC COLLECTION

1.30yr old gentleman with uncontrolled hypertension.
Uncontrollable BP for 1 year with enalapril, atenolol, water pills. Wt -60kg. No hyperthyroid symptoms. No renal/CVS/CNS symptoms. Smoked previously for 10yrs. Drink alcohol. Mother
has hypertension.
No AF, murmur. Unequal pulse +. No renal bruit.
Dx… Takayasu's arteritis.

2. 28 yes old lady, regular attender in asthma clinic. Today presented with acute breathlessness.
Salbutamol inhaler for asthma. Pain in lt calf. Travel to Switzerland 12 hrs flight last week. OC pills +. DVT + in mother. No history of miscarriage.
Physical examination normal.
Dx.. PE
Ex: dx. Invx. Which blood test will you do in suspected PE? Can you exclude PE if Doppler is negative.
3.60yr old gentleman had dyspnoea for five months. He had back pain for 3 years.

Ankylosing spondylitis patient taking celecoxib and ibuprofen comes with SOB for 5 months.
Smoking +.
AS features +. Chest wall expansion reduced. Ht and lungs normal.
Concern: what's wrong? Come back to normal?
Dx: chest wall deformity and reduction in chest wall expansion in AS patient

Ex: findings in lungs and heart? Causes of SOB in AS patient? Invx? Mgt?
4. Know RA patient comes with SOB.
RA hand deformity +. Lungs basal crepts +.
Dx: pulmonary fibrosis
5. 23 yrs old lady with weakness of rt side of body.
Weakness of rt side of body and slurred speech comes suddenly while having breakfast. 30 mins last. Blurred vision +. Facial weakness +. Claudication pain + when using arm repeatedly. BP 140/90 rt arm, 130/80 Lt arm. Taking amlodipine for hypertension.
Dx: Takayasu arteritis.
6. 40 yrs old gentleman comes with sudden weakness of rt half of body.
Transient weakness of rt side of body, cardiac operation done 5 yrs ago for coronary angioplasty. Very slow AF+.
Dx: TIA.

7. DM patient presenting with Loss of vision and Rt sided weakness.
8. 70yrs old man with Ht problem presenting with weakness of lt side of body with slurred speech and completely recover at 10 mins. AF+. MDM+.
9. 26 yrs old lady with painful legs.
Wt gain +. Missed period for 2-3 months.
Concern: serious? Curable?
Dx: Meralgia paresthetica

10. 50 yrs old gentleman comes to you with episodic diarrhoea.
Flushing +. Wheezing +. Diarrhoea +.
Dx: Carcinoid syndrome.
11. Know DM patient presenting with weight loss.
Dx: Thyrotoxicosis.

12. Known asthma patient presenting with palpitation.
Rt eye exophthalmos ? Thyrotoxicosis.
13. 57 yrs old lady referred from DM clinic for difficult control of blood sugar level.
Topical steroid use for skin infection. Herbal medicine for 4 months.
Concern: why sugar level difficult to control.
Dx: Cushing syndrome.
14. 54 yrs old gentleman who is a regular attender in diabetes clinic for 20 yrs. He was referred
for tingling sensation of both hands.
Dx: carpal tunnel syndrome with goiter.
15. 38 yrs old lady complaint of painful hands.
Dx: Peripheral neuropathy
16. % Hand Pain
Dx: RA
17. 60 yrs old lady in surgical ward admitted for hemorrhoids now complaining of joint pain of forehands and back pain.
Deforming polyarthropathy with back pain
No skin rash. Fever present for months.
Concern: infection? Disease activity?
18. Outside. 35 years old female vision problem and headache
Inside. Bumping into Rt side.
No blurring. No double vision
Headache. Generalized. No photpphobia.no lacrimation.no wt changes. No OC pills. No ICP.no
acromegaly feature. No past medical and surgical.no similar attack
No symptom of GCA.no pit tumor
O/E. Pronator normal.v acuity normal. V.field.rt HH .Fundus normal
Ex asked finding and lesion side

I said optic tract. Optic radiation.occipital
19. Outside progressive SOB and swallowing difficulty
Inside . Systemic sclerosis
No LOW.no Loa. No dysphagia. Only got heartburn
Surrogate didn't tell medical history
But i asked medication . She said PPI.
Cyclosporin. Prednisolone

Lung .clear
20. sudden loss of vision in rt Eye kco bicuspid
aortic valve

21.an elderly gentleman who had sudden loss of vision of his right eye.

K/c/o HTn underAmlodipine. Had CABG scar on chest and leg scars too.

Did ask all relevant questions and
examination.
Looked at fundus. Found it very
red.

When I asked ‘Do you have any concerns?’he didn’t understand. He was an old Bengali man.

The examiners gave him some clues and
He asked me “Questions?” I said ‘Yes’.

He said ‘Yes Yes. I have questions for you. Number 1.What is wrong?
Number 2. Is it permanent?
No 3. What can you do?’

Said Vitreous Haemorrhage
or retinal detachment. Missed to say CRVO.

Was so so so tense there.

22.There was an English patient with swelling of his Left lower limbs. Was a DVT. It was unprovoked and he was on Aspirin. No h/o any surgeries or travel. No features of malignancies.
He was a priest. They asked normal questions
on DVT.

23.MS - rt hemianopia with optic atrophy with h/o rt sided weakness

24.? Ankylosing with ILD/COPD - wheezes as
well as crepts - little odd

25.psoriatic arthritis

26.first episode of seizure in 55 years old
man.

****
My experience..i think that will help other.i have
passed from diet 3..Kolkata centre's
Exam started with St 2:

APS 2
Most horrible part of my exam bcz I appear 1st
time with 1st station.
St3
Cvs:
MVR with AF with pAH
Examiner was very happy with my performance
he thumb up &said best of luck Dr for exam
I was inspired
20/20
CNS:
Spastic para paresis
Dx,mx.inx.rx
19/20
St 4:
Mx of angry son due penicillin allergy
12/16
St 5
Bccc1
RA with ILD
Got 28/28
Bcc 2
Gout

28/28
St 1
Abdomen
CLD with Hepatomegaly
Examiner ask lots of questions
Got 19/20
Respiratory
ILD
Inv.mx.rx.dd
16/20
Grateful to ALLAH..
******
🔹 Station 1
✔ Resp
RA hand with COPD
Pleural effusion
✔ Abdomen
Alcoholic Liver Disease with Ascites
Upper abdominal scar (Thalassaemia+Splenectomy)
🔹 Station 2
Swelling of face and tongue (Angioedema)
✔ Station 3
🔹 CVS
CABG with MR

? Normal Heart
🔹 CNS
Spastic paraparesis with scar at back
Right homonymous hemianopia (Stroke)
🔹 Station 4
Young lady presents with Seizure and Right Temporal
abnormality on CT head, Neurosurgeon wants to do
MRI for confirmation
(Epilepsy)
Explain about uncertainty of diagnosis and MRI
✔ Station 5
🔹 BCC 1 : RA with ILD
🔹 BCC 2 : Sudden loss of vision (CRAO) with Biscuspid aortic valve disease.

******
Exam Experiences(of my Dear Brother) -Kolkata
- India April 2017
St2 changle in bowel habbit for 6 months gp
prescribed mebeverine no improvement.
Analysis of complaint large volume diarrhea
500ml for 5 times(small intestine pathology) no
blood no slim no relation to food no
improvement after fasting awake him at night
with urge to move bowel vague abdminal pain
,wt loss not significant.
Pmh of joint surgery,
Travel history last year.
What is your dx?ibd
Your dd ibs , caeliac,tropical sprue,cancer,hiv .
Invs?basic,stool,antibodies screen,faecal
calprotectin,endoscopy ,cancer markers?
Which antibodies to order?iga,ttg,ema
St3
Cardio
Mid sternotomy scar ,harvest graft ,no metallic
,systolic murmur at apex.
Dx MR,PHT
Invs,ttt
Neurology examine cranial nerves
Right Homonymous Hemianopia
Causes?leasion beyond chiasma tract
,radiation,occipital lobe,pisterior cerebral artery
occlusion,internal capsule.
Causes?invs?
St4 SAH on warfarin inr 4 with large onfarcts
specialist see no benefit from surgery talk to wife
BBN?
Qs what percentage can recover?why not ask about

organ donation?
BCC1 female bilateral arm pain
My dd was muscular vs rheumatological vs vasculitis
Postove finding pain with exertion absent pulse no systemic symptoms other criteria of takayasau absent
First dd was takayasu
What is your dd?other vasculitis, GCA,PMR,FM
One onvestigation to order?angiography
BCC2 hematemsis
Positive data nsaids tds last week ,pmh of colitis and on pentasa and moderate alcohol no finding no organomegaly no persistent vomiting or liver cirrhosus ridk or hepatitis
DD? PU vs Crohns VS MWS
Others varices ,malignancy
St1
Abdomen
Dark coloured patient with chevron scar no stigmata of cld no spleen with normal span liver, maxillary bossing ,no LNs, No ascites,
DD? Thalassemia major, HHC ,aih,psc,infiltration.
If this HHC what operation for this scar?
Hepatecomy,transplant
Chest
Patient with rheumatoid hand
COPD with bilateral basal crackles
Dx?OLD with ILD
Forget the rheumatoid what is other dx ? COPD
invs?
TTT?.

******
My exam experience in kolkata
st 4 pt non compliant to take steroid, kc
Addison. Husband pt of MS
St 5 (1)RA
LOC(2)
St (1)hepatosplenomegaly wth jaundice
ILD wth systemic sclerosis
St 2)return traveller bloody diarrhoea grandfather ca colon dx at age 78, 2nd cousin having UC.

St 3
1)mixed mvd with af with hf,
2)spastic paraplegia traumatic

******
My exam experience in kolkata
st 4 pt non compliant to take steroid, kc Addison.
Husband pt of MS
St 5 :
(1)RA
(2)LOC
St (1)hepatosplenomegaly with jaundice
ILD with systemic sclerosis

St 2)return traveller bloody diarrhoea grandfather ca
.colon dx at age 78, 2nd cousin having UC

St 3:
(1)mixed mvd with af with hf,
(2)spastic paraplegia .traumatic

******
calcutta , India -
sta1 . res - rt. pl effusion
abd - hepatomegaly with splenectomy
(heamolytic anemia)
sta2 . HB- 9.8 , c/o fatigue ?nsaid induced
sta3 . cvs - MS
cns - spastic paraplegia
sta4 . open TB , wants to go DAMA
sta5 . a) TIA
b) goiter with hyperthyroidism
Calcutta , India -
st1 liver transplant.
Chesy old with ILD in RA
Sts changle bowel habbit
St3 hemonymous hemianopia examine cranial n
Cardio biological valve with mr ,phtn
St5 bbn SAH with INR 4
St 5 takayasu
sta 2 - Hematemesis nsaids vs crohns

****
St 1 liver transplant.
Chesy old with ILD in RA
Sts changle bowel habbit
St3 hemonymous hemianopia examine cranial n
Cardio biological valve with mr ,phtn
St5 bbn SAH with INR 4
St 5 takayasu
Hemtatemsis nsaids vs crohns

Oman

1/24
******
Cycle 2
Lcc..htn pt with fainting .. family hx of fainting ? epilepsy? Tuberous Sclerosis?? Pt said no rash, no convulsions 😬 no weakness. other colleagues admit she has learning disabilities

Lcc2 ..joint pain ..morning stiffness ..sob..RA..ILD
Concern ..when she can return to yoga class
..
Communication...
Pt with tight dm control.. hx of hypoglycemic unawareness.. driving licence has been revoked.. pt taking bb ..should change it due masking hypoglycemia symptoms..

Communication 2...
Daughter worried about father 's condition, who developed amiodarone side effects (lung fibrosis). nobody told them about side effect😬.

Clinical:
Long front chest (from rt to left and extended to the back) scar with creps of lung (lung transplant)
Discussion about possible causes and management

Neuro.. LMN paraparesis with cerebellar sign

Abdomen..hsm.. thalassemia

Cardio..mvr..

*****
Clinical: AS, post Renal tx, hereditary spastic paraplegia, bronchiectasis,

communication:
pilot having pneumothorax wants to join job,
husband having swallow problem due MND for PEG,

long case:
hypothyroidism with OSA,
weight gain with hypothyroidism.

****
*Communication 1;medical error(antiepileptic not given during admission)
*Respiratory :kartganer
*LCC 1:Diabetic complications
*CVS :AS (for me as others said AR)
*CNS :Charcto marie
*Communication 2:counsel for IBS

*Abdomen:HSM with signs of CLD
*LCC2:Acute pancreatitis

****
Squh - morning cycle (day 1)

Lcc1 -weight gain, fertility issues - diagnosis was PCOS

Examiner q's were around - pcos, cushings and hypothyroidism.

LCC2 - asthma exacerbation, triggers dust exposure and recent use of NSAIDs.

Examiner questions about :
other differentials?
acute and chronic management of asthma?

Cardio - i felt it was AR (dominant with peripheral signs) other colleagues thought as mixed valve AS/AR.. examiner questions were around

Abdomen - there were 2 cases (they were alternating)
* i got renal transplant

Neuro - also 2 cases
* i got spastic paraparesis without sensory level

Pulmo - bronchiectasis (underlying cystic fibrosis)

Comm1 - temporal lobe seizure/gtcs - CT shows mass need to convince for MRI for further steps (a lot of hidden agenda, smoking/ driving and husband not working (i offered smoking cessation, social worker and stop driving)

******
10.2.2024
Oman centre
Day 3

Long clinical consultation:
1- IgA Nephropathy
2- nephrotic syndrome

Communication
1 - lymphoma with Hickman line
2- end life care with DNR

Clinical
CNS : Sensory motor peripheral neuropathy
CVS: VSD
Chest: Bronchiectasis kartagener syndrome

Abdomen : ADPKD on dialysis

******
Neuro-LL exam
Pt had mixed UMN and LMN signs for DDs
Examiner discussion along complete transection of spinal cord
Cardio-AS
Resp- COPD with left basal fibrosis
Abd- APKD on HD with permicath
LCC 1- OSA with metabolic syndrome
LCC 2- Diabetic retinopathy- Pt c/o vision loss, ESRD+, Neuropathy+
Commn 1 - bronchial asthma disease explanation, occupational concern as he is firefighter and exposed to smoke.
Commn 2 - pheochromocytoma delayed Dx
****
Kartegners. Bronchiec
Ar
PSMN.. Cmt
Huge gigantic abdomen with Distended veins. Very tender. Couldn't proceed with spleen kidney. Ascites.
Palmar erythema

Comm
Medical error dose missed during hospital stay.. Profession driver.

IBS.. All test normal concern cancer and cronhs task is to discuss about pros and cons of imaging and colonoscopy.

Lcc
Tummy pain last week alcohol increased
smoking
Job less
Stressed
6 months htn not on medication
Morning urine change
But no family hx positive
Mild rt and epigastruc tenderness.
Viva on acute abdomen acute pancreatitis.

Diabetic erratic control
Diabetic foot ulcer
PErMACATH on dialysis 3 times per week
Non compliant
No fflups
No dietary restrictions
No exercise
[10/02, 7:57 pm] +968 9493 5674: HX of passing stone also lst lcc
[10/02, 10:24 pm] +968 9493 5674: 3rd cycle 10/2/24

Com1 DNR
Resp Kartagener syn
LCC sore throat & cough ?IgA nephropathy or post streptococcal
Cardio Panasystolic murmur
Neuro peripheral sensorimotor neuropathy
Com2 Hickman & chemotherapy
Abdo splenomegaly
LCC facial swelling
****
*Communication 1;medical error(antiepileptic not given during admission)
*Respiratory :kartganer
*LCC 1: Diabetic complications
*CVS :AS (for me as others said AR)
*CNS :Charcto marie
*Communication 2:counsel for IBS
*Abdomen:HSM with signs of CLD
*LCC2: Acute pancreatitis

***---
Muscat 9.2.24

Autonomic neuropathy

Post renal transplant PT with leg twitching, headache with vision problem

Med errors wrong insulin given

Delirium explain to angry PT , mom given steroids thinking headache could be GCA , as per consultant GCA unlikely

Renal transplant
Slow rising pulse AS with ?

COPD

Mixed umn lmn with sensory neuropathy till xiphisternum

Oman centre
8.2.2024
3rd cycle (day 1)
armed force hospital

station - 1
Communication 1; convince the patient to start anticoagulant

Chest; Bronchiectasis

station - 2
Long clinical consultation - SOB in RA case of lung fibrosis

station - 3
CVS: mitral regurgitation. Marfan syndrome.

Neuro: myotonia dystrophica

station - 4
Communication 2; gliclazide overdose

Abd ; myeloproliferative

station - 5
Long clinical consultation: hand pain and headache in acromegaly

****
Rh exam today cycle 1
LCC .
1_ DM neuropathy with Charcot joint
2- twisting in legs in ESRD on HD.
? Hypocalcemia

Communication.
1- medical error hypoglycemia due to overdose insulin

2- steroid induced psychosis

Clinical
Resp. COPD

Cardio AS

Neuro .spastic paraparesis with sensory level

Abd : APKD

🟣🟣🟣🟣
Diet-3,2023 Oman,AAH
****
OMAN DIET 3 2023

My exam cases are Cardio Mechanical Aortic valve replacement
Abdomen Polycystic kidneys with renal translation ((2 different findings)) no fistula
Neuro Peripheral neuropathy secondary to DM and renal failure on dialysis
Chest Bronchiectasis secondary to Kartegner syndrome

The long clinical consultation cases :
Autonomic diabetic neuropathy with spastic paraparesis and peripheral neuropathy and renal failure with transplanted kidneys and diabetic retinopathy 🙃

The second case: no findings. Transient global amnesia on background of migraine they wanted TIA and medication overuse headache.

My communication cases Medical error mislabeled HIV sample need to do a third sample and patient with infective endocarditis needs discharge against medical advice

💠💠💠💠💠

LCC:chronic headache, both hand numbness and knee pain
= acromegaly
Patient did not allow for examination

Daughter concern:
Tx
Will HTN , DM recover?
What's the investigation?

LCC2: hand pain plus breathlessness

No sign of deformity ,no synovitis
No raynaud or tightness
In lung: creps bilaterally
I found jvp elevation,loud s2

I gave : RA plus ILD
MCTD

concern was ttx

Examiner ask about inv,management
About tx of ILD,spirometry
O2 criteria
And also PAH

Communication:
1.GI Bleed due to NSAID FOR BACK PAIN ,,CANCELLED DUE TO EMERGENCY OGD angry patient

2.RA on MTX ,delayed appointment and want to be on infliximab but latent TB is positive. She doesn't accept for ttx.
And she lives with her motger whome has TB

2 children 5 and 10 years old

Communication:
1.GIB due to NSAID FOR BACK PAIN ,,CANCELLED DUE TO EMERGENCY OGD angry patient

2.RA on MTX ,delayed appointment and want to be on infliximab but latent TB is positive
She doesn't accept for ttx
And she lives with her mother who has TB
2 children 5 and 10 years old

Clinical:

CARDIO:sys ejection radiate to carotid
Diastolic murmur
Bouncing pulse in neck
I put mixed AS but i want sure about AR OR MS

NEURO:
LI:LMN with weakness in distal more in lf leg ,impaired pinprick and saft up to shin
Dorsal column:nl
Examiner don't let me do gait ot cerebellar
He said gait is broad based and rumberg is negative

I put polyneuropathy for ddx but i was confused about cerebellum
Chest:
Barrel chest,proling respiration,wheeze
And coarse crackle plus wheeze
I put bronchiectasis,copd,bronchitis

He ask what else for creps:i said CHF but he doesn't have any sign
Pneumonia

He ask about investigation,mng

Abd:
Splenomegaly (huge) ,mild icteric.
Ascitis(i wasn't sure)
No CLD

Iput hematologic
Infection
Inflammation
He asked why not portal HTN?
i said usually will give hepatomegaly
But it can be.

****
OMAN DIET 3 23

Diet 2023/3
Royal hospital, 3rd cycle

Lcc1 :
outside : dizzy nausea vomiting 3 days
Very low BP

Inside
3 days before a severe headache now not much headache.
Loss of libido and mild confusion

Got-12/28

Lcc2
Know DM HTN
% of tiredness, weight gain lower back pain

28/28

Com 1
Toothache paracetamol overdose
Level high
Nac infusion 10 hours more to Finish
Asking for discharge 14/16

Com 2
Know epilepsy diagnosed at childhood
On lamortregine

Not getting pregnant
Need to stop 16/16

Cardiology scar with click 18/20

Respiratory
Bronchiectasis with Kartagener 16/20

Abdomen
Renal transplant 15/20

Cns
Sensory motor neuropathy 18/20

******
DIET 3 AJMAN NOV
 communications:
1 - Type 2 DM on insulin therapy admitted with cellulitis: taking glargin 22 HS and lispro 12 TDS.

Counscelling about medical error as the pharmacist discover that the patient recived double dose lispro twice (24 U instead of 12) and the patient is totally asymptomatic.

2- Known case of progressive bulbar palsy had recent video fluroscopy which show no movement of the the esophagus. Counscel him about the disease and mode of nutrition(open not specified)

: LCC:
1- 48 years old with Unilateral Loss of vision from outside- (TIA)

inside + ve history of Rheumatic Heart Disease with MVR and Non-compliance to anti-coagulation.

2- 20 years Old male with progressive weakness , balance and coordination from outside.

From inside, 10 years progressive weakness on examination (Reduced power+ DC affection + PN+ Cerebellar ->

DX: Spinocerebellar Ataxia /FA

CLINICALS
Neuro. Stroke spastic hemiparasis
Abd. Thalasemia
Cardio MR
Resp?? ILD
*****_*
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inside + ve history of Rheumatic Heart Disease with MVR and Non-compliance to anti-coagulation.

LCC2- 20 years Old male with progressive weakness , balance and coordination from outside. From inside, 10 years progressive weakness on examination(Reduced power+ DC affection + PN+ Cerebellar -> DX: Spinocerebellar Ataxia /FA

CLINICALS
Neuro. Stroke spastic hemiparasis
Abd. Thalasemia
Cardio MR
Resp?? ILD

******
SQUH
LCC -
1.PCOD weight gain and sub fertility
2. TIA (confused by headache probably induced by Amlodipine)

Communication- ICD was deactivated for dermatological procedure and discharged without reactivation- Talk to angry son (Error)
2. Meningococcal meningitis with residual deficits
Talk to the wife regarding the poor prognosis (repeated)
Clinical
Cardio- MVR (I think 🧐)
Neuro - Cerebeller Syndrome, Young man probably degenerative disease

Abdo- KT in LIF with joy stic scar in right

Chest/ For me Bronchiectasis but I am also not confident

****
DIET 3 OMAN TODAY

LCC1
Back Pain, 2 weeks.
mechanical pain
Loss of wt. Sweating & Fever 2 weeks.

No finding on examination

LCC2
Headache with increased ICP
Blurring of vision
No fever no neurological manifestation
Vision examination normal.

Fundus examination :examination by examiner

PCKD . HTN. RENAL transplant.

Communication
Thyrotoxicosis explain and medication propranolol and carbimazOle

Communication
Medical error
False dose of insulin given

CLINICALS
Pckd with CVC for dialysis
COPD
Mixed mitral and aortic. ??
Spastic paraplegic with sensory level
Transverse myelitis discuss.

****
♦ *SQUH TODAY,OMAN*
Long Case
Hypothyroidism ⏩⏩weight gain,
tiredness, OSAS⏩⏩Obese

Communication
Pneumothorax
PEG tube

Abdomen⏩PCKD
Left loin scar,Vermicus catheter
Chest⏩ILD
Cardiology ⏩MVR
Neurology ⏩ CMTD, HSMN
Pt♦hypotonia,pes cavus,absent vibratory sense left side, Joint⏩Intact, Pin prick⏩N
✍🏻✍🏻✍🏻

2/23

Royal hospital OMAN CENTER
1st courosal

St 4:
80 y ihd,dm,copd come with cough,fever,sob
Cxr suspect empyema .
As pt has delirium medical team decided to make to him pleurodesis as no one was with him and no one answered the phone..

Then pt become agitated and pulled it then medical team gave him sedation and his condition deteriorated and will shift him to hdu as his prognosis now is poor.

Task:talk to son about his condition.

Examiner:if pt condition is bad and having alot of sons and daughters who u will call first??
Will u do for him mechanical ventilation or not!!!
Ask about every ethical issue how to apply even justice how to apply in this scenario??

St 5
1: fever,vomiting,constipation in ckd pt using peritoneal dialysis.

2:tiredness and back pain in pt having htn,dm,and renal transplant.

St 1:
Resp:kartagner ,,
examiner:if pt develop hemoptysis and u r oncall night alone what will u do?
which dr u will call??😳😳..
Abd:renal transplant in old pt (jaundiced!!)

St2: 30y male collapse 1st time after standing long time in bank wetting his pants..
Family history his cousin has epilepsy.
No cardiac s
No neuro s

Diagnosis:Vasovagal attack.
Concern:can I drive?
Is it epilepsy?
Will it reoccur?

*

1/23

Cardio: Normal patient

Neuro: LMN facial

Abdomen multiple scars ? Tx

Chest : bronchiectasis

History: lithium toxicity

Communication fight fighter BrOnchial asthma To convince to change the job

St5

Discitis

TGA

I heard functional systolic murmur ; I said systolic murder not referred

I said aortic stenosis could be HOCM/ He was young

Transient global amnesia
Lymphoma and TB on top

Pakistan

New Biologics below are *safer in RA with latent TB*

Golimumab
Tocilizumab
Abatacept
Tofacitinib

Rx for latent TB

Isoniazid
Rifampicin

For *4 months*
Also adding hydroxychloroquine with DMARDS decreases risk of Tb

2/24

10/08/2024

Lahore Evening Carousel

CVS....MR +AS

Neuro....asymmetrical LMN monoparesis with sensory loss… plexopathy

Abdomen...hepatosplenomegaly + jaundice + ascites

Resp....unilateral pleural effusion...viva on tb

LCC 1...ch. diarrhoea young female...no red flags.normal exam....IBS

LCC2...constipation in a 60 yrs old male.... Hypothyroid....

.inside:weight gain...fatigue. cold intolerance.....no features of hypercalcemia.....

Comm1...epilepsy...disease and management explanation

Comm 2....NSCLC Previously now paraplegia..MRI mets..

Explain the condition discuss management options

10/08/2024

Lahore Morning Carousel

Lcc: Single episode of collapse with palpitations with positive family History

Lcc : Polyarthritis RA

Neuro: cerebellar syndrome with peripheral neuropathy in upper limbs

Cardio : Dextrocardia with AS

Abd : Hepatosplenomegaly

Resp : Copd with infective exacerbation/ Bronchiectasis

Comm 1: IBS counselling starting amitryptaline

Comm 2 : Medical error wrong medication

09/08/2024
Lahore Evening Carousel

Lcc : SOB and cough copd/ ILD/ HSP

Lcc : joint pain psoriatic arthropathy

Neuro : Differential weakness in lower limbs with mix features of umn and lmn

Cardio :MS

Chest : COPD with infective exacerbation/ COPD with ILD

Abd : hepatosplenomegaly ascites for psoriasis

Comm 1; Active TB wanting discharge

Comm 2 : MND for PEG

09.8.24 *diet 2*
Lahore Morning

Cardio: MS

Neuro: Essential tremors vs.
Cerebellar tremors

Abd: PKD

Chest: Bronchiectasis

LCC 1 : Obstructive jaundice for DDx

LCC 2: hand pain and arm pain unilateral for ddx vasculitis, PMR, CFS

Comm 1: wrong dose drug medical error

Comm 2 : recurrent pneumothorax for chest tube case

Lahore Diet 2 *08/08/2024*
Evening Carousal

Cardio... MVR

Neuro...Cranial nerve examination ptosis bilateral
Case of MG

Comm 1: wrong insulin dose medical error

comm 2 : start of mtx for RA

Resp ; ILD

Abd: Jaundice with hepatosplenomegaly

Lcc 1 : Sob in a patient of RA

LCC 2 : pain in Epigastrium, burning pain non responding to ppi. no red flags for.
DDx.

Lahore Morning carousel
08/08/2024

LCC 1.. BACK PAIN 1 yr LOWER BACK ... ankylosing spondylitis (advance disease unable to move neck , shober only 1.5 cm)

LCC 2....COUGH FOR 8 month .
Inside history of Bronchiectasis . Previous pneumonia now phlem cough hemoptysis and SOB .
And also farmer

Communication
1. B streptococcal infection given benzyl penicillin develop steven johnson now shifting to icu and intubation .

2. Patient with previous diarrhoea was high risk for DVT , pt was not given . Now develop dvt .

Chest.....PLEURAL EFFUSION .

Cardio... C/ O PALPITATION . APEX BEAT WAS NOT clearly palpable . Pulse normal volume . MR / AS

Cns....Spastic paraparesis no sensory level .

Abd...psoriasis rash plus hepatomegaly 1_2 finger and massive spleenomegaly .
More interested about spleenomegaly .
Myeloproliferative.

07/08/2024

Lahore Evening Carousa

Lcc 1 : abdominal distension and abdominal pain for 1 month
Budd chiari, mass lesion,ccf

Lcc 2 : constipation and abdominal pain hypothyroidism

Comm 1 ; insulin compliance

Comm 2 : Pneumatic dilatation scenario

Resp : COPD

Abd : jaundice with epigastric mass

Cardio: mixed valve lesion MS MR

Neuro ; Spastic paraparesis with absent reflexes and upgoing planters

07- Aug - 2024
at Lahore

Lcc1. Ch diarrhoea , 34 yrs, relieved with defecation (DD Coeliac ds, IBS)

Lcc2. Dysphagia with SS

SHORT CASES= CARDIO 1. MS+AR

NEURO = PERIPHERAL SENSORY NEUROPATHY

RESP = pleural effusion L sided

Abdomen = Anaemia + jaundice + spleen with tender abdomen

Communication 1 = HTN, lipid profile deranged , family H/O Cardiac disease, brother had CAD at young age, counsel Renal ultrasound .

Communication 2= Functional Disorder, surrogate thinks she has SLE.

******
07/08/2024
Lahore Morning carousel

Lcc 1 : chronic diarrhoea

Lcc 2 : dysphagia in systemic sclerosis

Cvs: diastolic murmur Ar with MS

Neuro: peripheral sensory neuropathy

Abd: CLD

Resp: Effusion

Comm 1 : Functional lupus
Comm 2 : Counselling for USG kub to rule out RAS for secondary hypertension

******
06/08/2024
Lahore Evening Carousel

Comm 1 : medical error missed dose of antibiotic

Lcc 1; bone pain and tiredness inside hypercalcemia features

Abd: ascites with hepatosplenomegaly

Comm 2: ACE inhibitor with non compliance

Resp; bronchiectasis

Lcc 2 : RA with acute flare

Cvs : AVR

Neuro: Myelopathy/ demyelinating disease

*****
06/08/2024
Lahore

Cvs: AS
Chest: Pleural effusion with consolidation
Neuro: unilateral lmn leg weakness
Abd: ADPKD

Lcc 1: painless jaundice for ddx

Lcc 2: Sob

Comm1: Counselling of daughter about Cecal Cancer

Comm 2: new diagnosis of UC in young lady

*****__
24 /5/24 ISLAMABAD PAK

Communications were
1. Functional headache
2. TB pt doesnt want to start med and wants to visit mom in UAE

Long cases were SOB with hemoptysis from 2 days

And headache for 1 month

Short cases were proximal weakness of lower limbs, murmur in aortic area, asthma pt, jaundice pt no hepatosplenomegaly

*****
Rawalpindi cases today 25th May

LCC 1:
Fever for 5 months along with blood thru back passage.. blood with stools and sometimes blood without stools
No history of loose motions, hx of contact with unpasteurised milk, history of intake of antibiotics 5 months back at the start of this fever... took azithro and cipro for 2 weeks, wt loss of 10kg in last 4 months, no other source of infection, no contact with HIV or TB person, I examined abdomen, chest and hands, face. No positive finding.
Forgot to check lymph nodes.
I made DDs of
CA colon
Pseudomembranous colitis
Brucellosis

LCC 2
Sob
Cough
Patient had ILD

Communication 1:
Ulcerative colitis leading to high grade dysplasia
Break bad news and counsel about proctocolectomy
I drew for the patient and told in detail, told about colostomy bag and Fups and occupational and financial support as well

Comm 2:
NAFLD
Counsel about lifestyle changes
This station was good

Cardio
AS (some were saying AS with AR, I only found AS)

Neuro
Flaccid paraparesis, no sensory abnormality, both sensations intact
I did not find wasting.
I gave DDs of
GBS
CIDP
Periodic paralysis

Abdomen:
Anemia plus spleen
DDs
Hematological malignancy
Hemolytic anemia

Resp
Patient had wheeze and crepts
ILD / bronchiectasis

*****

Rawalpindi 22.5.24 diet 2

Yasmin 66 years
Died 2 days back, death cert done,
Talk to son who came 2 days later and he was angry why i was not informed that my mother had cancer and she was this serious
Long scenario tha

Mother got initail chest infection, gp treated no response, then became SOB , came to hosp Massive pleural effusion, biopsy showed adenocarcinoma, with imaging showing metastasis, onco dr said to start chemo but then she got pneumonia and died in 2 days
..

Any idea regarding this
[25/05, 12:19 am] +966 58 058 9255: *Rawalpindi cases*
MAY 24

Communication1
open TB case, wants to get discharged to see her mother in another country who recently had a stroke.

Communication 2
Fibromyalgia.
Explain that no further investigations will be done
[25/05, 2:28 am] +91 94351 71036: *Rawalpindi cases today 24th May*

Comm1: open TB case, wants to get discharged n see her mother in another country who recently suffered from stroke. Task: Explain the risk of spread of infection to others

Comm2: Fibromyalgia,, Task: Explain that no further investigations will be done

LCC1: RA with 2 day h/o cough n sob,, ex smoker,, h/o long flight to Australia 2 weeks ago n family h/o thromboembolism

LCC 2 Headache,, Migraine

Chest,, asthma
Neuro,, MS / transverse myelitis
Abdomen,, HSM with jaundice
Cvs,, AS

*****
Rawalpindi centre
23rd May
Evening cases

LCC1: persistent vomiting for 3 days; medication Hx ibuprofen n antibiotics

LCC2: palpitations, goitre, Hyperthyroidism

CVS: AR
CNS: Parkinson
Resp: ILD
Abdomen: deep jaundice

Comm1: persistent diarrhoea, UC diagnosed on biopsy (explain diagnosis)

Comm2: Pneumothorax 2cm. Task,, admit n chest drain.

rawalpindi evening 23.5.24 *diet 2*

LCC1 : hyperthyroid
Lcc2 : vomiting sec to nsaid induced gastritis or theophylline toxicity

Communication1
 ulcerative colitis explain dis and management

Comm 2

Pneumothorax explain dis and management

Lung IPF
Neuro stroke
Abd viral heaptitis
Cardio AR

[***---*--****]
Today cases mam
LCC
66 yrs with headache from 3 mnths with episodes of anxiety
Vitals normal.
(Surrogates mention that he was HTN and hypothyroid) BP was 110/70

2nd LCC
Progressive lower limb weakness from 1 year

Age 39,
Vitals N, no previous comorbid

Cvs it was ESM at A area with radiaton to carotid
Pulse was low volume, i made it AS

Cns was it young man with horizontal nystagmus
Command examine cranial nerves

Rest were normal and i didnt found any cerebellar lesion

Git
Palor,, half and half nail with normal liver span but splenomegaly and shifting dullness
I made it CLD ,

Communication 1
Young lady with jount pain fatigues, herself cocnern was lupus, bit all blood test and imaging of joints were normal

Task was to talk to her
But she was not satisfying why they are normal😊

Communication 2
Yasmin 66
Died 2 days back, death cert done,
Talk to son who came 2 days later and he was angry why i was not informed that my mother is died
Long scenario tha
Mother got initail chest infection, gp treated no response, then became SOB , came to hosp
Massive pleural effusion, biopsy showed adenocarcinoma, with imaging showing metastasis, onco dr said to start chemo but then she got pneumonia and died in 2 days

*****
rawalpindi evening 23.5.24 *diet 2*

LCC1 : hyperthyroid
Lcc2 : vomiting sec to nsaid induced gastritis or theophylline toxicity

Communication1
 ulcertive colitis explain dis and management

Comm 2

Pneumothorax explain dis and management

Lung IPF
Neuro stroke
Abd viral heaptitis
Cardio AR

[*******--
 Neruo Lcc,, Flaccid paralysis with dorsal column loss and pes cavus.

Resp,,
RT thoracotomy scar
RT LL lobectomy
[23/05, 6:49 pm] +92 336 7519026: *Rwp center*
23/05/2024
Morning cases

Comm 1: young female had normal SVD of a healthy son, diagnosed to have Group B streptococcal based on isolation from vaginal swab. So to prevent child getting infection during delivery and as part of standard treatment she was given Penicillin IV, on the 3rd day the mother reacted with rashes on the face and body and she was diagnosed to have SJS with multiple organ insufficiency involving the Kidney and the Liver (deranged LFT, RFT). Now she become confused requires ICU transfer and possible intubation.

Explain to husband

Cvs: MR
Abdomen: renal transplant

lcc1: hypothyroidism

Lcc2: recurrent pulmonary embolism due to DVT, likely secondary to thromboplilia (mother had died of clots).

Comm 2: diabetic female , non compliant to insulin, developed proteinuria. Also has high BP with retinopathy. ACEi started but GP worried she would remain noncompliant. Explain proteinuria with stress on compliance.

islamabad
day 1
21.5.24 diet 2

Lcc1
sob fatigue
Black stools melena
Back Pain stiffness
Dx ibuprofen biologics

Px Ankylosing spondylitis

Lcc2 left arm weakness
2 month then right arm gradual onset

Examination

Lt arm wasting flaccid and facilitation

Ddx mnd

Cardio MR
Neuro. Facial nerve palcy

Communication 1
Patient developed left leg pain and diagnosed as DVT
So discuss diagnosis and treatment

Communication 2
Young man diagnosed with hypertension and was pit on anti hypertensive medications now counsel about disease and treatment and lifestyle modifications

*****_

Rawalpindi 22.5.24 diet 2

LCC
66 yrs with headache from 3 mnths with episodes of anxiety
Vitals normal.
(Surrogates mention that he was HTN and hypothyroid) BP was 110/70

2nd LCC
Progressive lower limb weakness from 1 year

Age 39,
Vitals N, no previous comorbid

Cvs it was ESM at A area with radiaton to carotid
Pulse was low volume, i made it AS

Cns was it young man with horizontal nystagmus
Command examine cranial nerves

Rest were normal and i didnt found any cerebellar lesion

Git
Palor,, half and half nail with normal liver span but splenomegaly and shifting dullness
I made it CLD ,

Communication 1
Young lady with jount pain fatigues, herself cocnern was lupus, bit all blood test and imaging of joints were normal
Task was to talk to her
But she was not satisfying why they are normal😊

Communication 2
Yasmin 66
Died 2 days back, death cert done,
Talk to son who came 2 days later and he was angry why i was not informed that my mother is died
Long scenario tha
Mother got initail chest infection, gp treated no response, then became SOB , came to hosp
Massive pleural effusion, biopsy showed adenocarcinoma, with imaging showing metastasis, onco dr said to start chemo but then she got pneumonia and died in 2 days

****
Rwp evening cases

21/05/24

STATION 1

COMMUNICATION.
PT OF ACUTE EXACERBATION OF COPD ON THEOPHYLLINE STARTED THIS TIME ON CLARITHROMYCIN DEVELOPED SEIZURES.....DRUG DRUG INTERACTION.....MEDICAL ERROR.

SHORT CASE.
ASTHMA
COPD

STATION 2
LCC
CONGESTIVE CARDIAC FAILURE

STATION 3
AS+AR

MS/STROKE

STATION 4
COMMUNICATION
PATIENT K/C HTN ON ACEI +NSAIDS FOR BONY PAINS DEVELOPED AKI DUE TO DEHYDRATION.
COUNSEL FOR HEMODIALYSIS.

ABDOMEN SHORT CASE
RT SIDED NEPHRECTOMY

STATION 5
LCD
CHRONIC PANCREATITIS.
****
Communication 1

Patient was admitted with sob and wasnt relieved pleural effusion came out as malignant and adenoma carcinoma while primary source was not known patient was advised for chemotherapy but developed pnemonia and died of it 2 days back you have made death certificate and now son has arrived to talk to u..

Why u disnt tell me I cud have come earlier

Y chemo wasnt started

Communication 2.
Functional lupus

Lcc1 weakness or legs and now arms as wel for 6 mnth to 1 year on examination lmnl with loss of proprioception

No dx/fx/alcohol.

Ddx gbs/cidp/smneuropathy

Lcc2.
Headache px Na 126 and hypothyroid
Dx thyroxcin and thiazide

PE.goiter palpable

Siadh
Hyponatremia due to thiazide

Abdomen
Hepatospleenomegaly

Cvs AS/hocmp

Neuro .nystagmus with no other signs

Chest. Lat thoractomy scar with deviated trachea and crepts other side.
****
[22/05, 2:30 pm] +92 336 7519026: Today cases mam
LCC
66 yrs with headache from 3 mnths with episodes of anxiety
Vitals normal.
(Surrogates mention that he was HTN and hypothyroid) BP was 110/70

2nd LCC
Progressive lower limb weakness from 1 year

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Yasmin 66
Died 2 days back, death cert done,
Talk to son who came 2 days later and he was angry why i was not informed that my mother is died
Long scenario tha
Mother got initial chest infection, gp treated no response, then became SOB , came to hosp
Massive pleural effusion, biopsy showed adenocarcinoma, with imaging showing metastasis, onco dr said to start chemo but then she got pneumonia and died in 2 days

[22/05, 2:33 pm] +92 336 7519026:
 Neuro Lcc,, Flaccid paralysis with dorsal column loss and pes cavus.

Resp,,
RT thoracotomy scar
RT LL lobectomy

&*****
[22/05, 3:27 pm] +92 324 0580669: *Rwp evening cases*
21/05/24 *diet 2*

STATION 1
COMMUNICATION.
PT OF ACUTE EXACERBATION OF COPD ON THEOPHYLLINE STARTED THIS TIME ON CLARITHROMYCIN DEVELOPD SEIZURES.....DRUG DRUG INTERACTION.....MEDICAL ERROR.

SHORT CASE.
ASTHMA
COPD

STATION 2
LCC
CONGESTIVE CARDIAC FAILURE

STATION 3

AS+AR

MS/STROKE

STATION 4
COMMUNICATION
PATIENT K/C HTN ON ACEI +NSAIDS FOR BONY PAINS DEVELOPED AKI DUE TO DEHYDRATION.
COUNSEL FOR HEMODIALYSIS

ABDOMEN SHORT CASE
RT SIDED NEPHRECTOMY

STATION 5
LCD
CHRONIC PANCREATITIS.
[22/05, 3:28 pm] +92 324 0580669: *Rawalpindi 22.5.24 diet 2*

LCC
66 yrs with headache from 3 mnths with episodes of anxiety
Vitals normal.
(Surrogates mention that he was HTN and hypothyroid) BP was 110/70

2nd LCC
Progressive lower limb weakness from 1 year

Age 39,
Vitals N, no previous comorbid

Cvs it was ESM at A area with radiaton to carotid
Pulse was low volume, i made it AS

Cns was it young man with horizontal nystagmus
Command examine cranial nerves

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Palor,, half and half nail with normal liver span but splenomegaly and shifting dullness
I made it CLD ,

Communication 1
Young lady with jount pain fatigues, herself cocnern was lupus, bit all blood test and imaging of joints were normal
Task was to talk to her
But she was not satisfying why they are normal😊

Communication 2

Yasmin 66
Died 2 days back, death cert done,
Talk to son who came 2 days later and he was angry why i was not informed that my mother is died
Long scenario tha
Mother got initail chest infection, gp treated no response, then became SOB , came to hosp
Massive pleural effusion, biopsy showed adenocarcinoma, with imaging showing metastasis, onco dr said to start chemo but then she got pneumonia and died in 2 days

Diet 1/24

*****
PINDI PAK DIET 1 24

[01-29, 8:43 a.m.] Dr Umair Alam: One long case was dysphagia
one long case was COPD with pulmonary hypertension.
[01-29, 8:43 a.m.] Dr Umair Alam: Short case Abdome..LT
Short case Respiratory..lobectomy/Pneumonectomy
Short case neuro...LMN command was upper limb and it was proximal myopathay pt was having CVP line in Neck he was mysthenia gravis patient middle age patient wid no thymoma scar.
CVS short case was HOCM
communication 1...APKD
Communication 2....Angrey patient son was concerned regarding steriod induced psychosis ie steriods was given in suspicion of GCA...Howerever the consultant proven that its not the diagnosis and pt was stopped from steriod and the admitted to the hospital.

*****
Lahore 2.3.24
Cvs
Avr with ICD
Cns
Parkinson
Abdomen
Hepatosplenomegaly
Resp
Collapse with patent bronchi

Lcc
Systemic sclerosis
With ILD

Lcc 2

Thyroid eye disease

Cc
Palliative care

Breaking bad news

*****
LAHORE DIET 1 third carousel 2/3/2024

Lcc..60 yrs old lady with joint pain stiffness and back pain for 4 months.

LCC 2.. Young lady 34 yrs with joint pain and rash(systemic sclerosis)

Communication 1... Ibs explanation

Communication 2... Error tramadol +epilepsy

Cvs.. MS OR MR don't know

Rs... Rt sided effusion

CNS... Upper limb wasting with occipital area neck scar(lmn signs of wasting fasciculations and hypotonia)

Abd... Tense ascites + Spleenomegaly

*****
Today cases lohore
Cvs
Avr with ICD
Cns
Parkinson
Abdomen
Hepatosplenomegaly
Resp
Collapse with patent bronchi

Lcc
Systemic sclerosis
With ILD

Lcc 2
Thyroid evey disease

Cc
Palliative care

Breaking bad news

******
Pakistan 1.3.24

CVS.. MITRAL STENOSIS
CNS...CMTD
GIT...CLD WITH CLUBBING
RESP..LOBECTOMY WITH RHONCHI IN CHEST

LCC 1..
FATIGUE..
INSIDE : HYPOTHYROIDISM .. PT WAS TAKING AMIODARONE.

LCC 2..
COUGH, HEMOPTYSIS...
INSIDE: BRONCHIECTASIS.. VS PULM TB VS LUNG Ca.

Communication: 1.. pt on hemodialysis wants to quit on dialysis because of the daily routine of dialysis.

Communication 2... PD, Admitted of Pneumonia..now drowsy missed dose of anti parkinson drugs in hospital
Address daughter concern.
*****
DIET 1 2024 LAHORE CENTER
DATED : 1/3/2024

Short cases
CVS : AS with CABG
Neuro : left cerebller syndrome
Resp : left sided pleural effusion
Gi : mass with ascites/ pkd??

Comm 1 : fire fighter having asthma . Asthma diagnosis , treatment , concerns(what about my job? Dont tell my wife)

Comm 2 : sle diagnosis & kidney biopsy(counsel the reluctant patient)

LCC 1 : ankle swelling outside . Inside uncontrolled diabetes & neuropathic ulcer with charcot joint

LCC 2 : c/o epigastric pain from 2 weeks . Gastric ulcer . Inside Acromegaly female spot diagnosis and on hx diagnosis was - MEN1.

****
Lahore

Communication =
CAP- to discuss DNaCPR.
2.Amiodarone induced lung fibrosis.

Long case - huntington
2- Ra related ILD

Cvs= AS
Abd=hepatomegaly- colorectal Ca with colostomy and liver mets.
Resp= bronchiectasis.
Cns = parkinson

*****
⬇️ LAHORE DIET 1 2024
Dated 28/2/2024

Long consultation 1:
50yr female Complaining of Fatigue and Tiredness for the last 6 months.
Hb and Thyroid normal...
On Hx: she told that she is having itching for the last 6 months...
On examination: Xanthelasma and Hepatosplenomegaly with dark complexion.
Viva on Hepatosplenomegaly...
Concern: is it infection...

Communication skills..
Medical error..
Patient had Hypoglycemia because of wrong insulin...
Mixtard given instead to Regular insulin....

Long consultation 2:
55yr old male complaining of tiredness and fatigue for some time...
His Hb is 10.8.. taking multivitamins but are not helping..
On Hx: SOB and chest tightness on exertion...
On auscultation: AS murmer...
Smoking present...
Forgot to screen for IHD...
Concern: will he be able to walk like before...

Neurology
Spastic paraparesis+ normal cerebellum + absent ankles with upgoing planters....
Examiner wanted to hear Mix lesion like Upper motor Neuron lesion with Neuropathy .

Communication skills:
Patient had started Metformin on Type II DM...
Don't know whether it's type I or II...
Give future plan and manage his concerns...

Concerns list:
Should I inform DVLA.
Won't you repeat my Antibodies test you have done.
Will Sugar affect body.
Can't you start Insulin in me..
I have tried everything and my weight is not losing...

Abdomen :
Massive ascites.
Respiratory: Bronchiectasis

*****
[28/02, 11:39 pm] +971 55 369 4919: ⬇️ LAHORE DIET 1 2024
Dated 28/2/2024
[28/02, 11:39 pm] +971 55 369 4919: Long consultation:
50yr female Complaining of Fatigue and Tiredness for the last 6 months.
Hb and Thyroid normal...

On Hx: she told that she is having itching for the last 6 months...

On examination: Xanthelasma and Hepatosplenomegaly with dark complexion.

Viva on Hepatosplenomegaly...

Concern: is it infection...
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Medical error..
Patient had Hypoglycemia because of wrong insulin...
Mixtard given instead to Regular insulin....
[28/02, 11:39 pm] +971 55 369 4919: Long consultation 2:
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His Hb is 10.8.. taking multivitamins but are not helping...

On Hx: SOB and chest tightness on exertion...

On auscultation: AS murmer...
Smoking present...
Forgot to screen for IHD...

Concern: will he be able to walk like before...
[28/02, 11:39 pm] +971 55 369 4919: Communication skills:
Patient had started Metformin on Type II DM...
Don't know whether it's type I or II...
Give future plan and manage his concerns...

Concerns list:
Should I inform DVLA.

Won't you repeat my Antibodies test you have done.
Will Sugar affect body.
Can't you start Insulin in me..
I have tried everything and my weight is not losing...
[28/02, 11:39 pm] +971 55 369 4919: Short case:
Spastic paraparesis+ normal cerebellum + absent ankles with upgoing planters....
Examiner wanted to hear Mix lesion like Upper motor Neuron lesion with Neuropathy .
[28/02, 11:39 pm] +971 55 369 4919: Abdomen :
Massive asciits.
[28/02, 11:39 pm] +971 55 369 4919: Respiratory: Bronchiectasis
******
Pakistan 28.2.24 3rd crousel

Cardio : severe Mr
Resp: copd with bronchiatasis
Neuro: bilateral spastic paraparesis
Abdomen: massive ascites

Comm1: young male with type 1 DM given wrong insulin and had 1 episode of hypoglycemia. Med error counciling

Comm2: 27 male admitted with tiredness, diagnosed as type 2 dm and htn, started on metformin and ramipril. Concern y I don't have type 1 dm.

LCC1. 50 male with history of tiredness and fatigue. Hgb 10.8 not responding to iron tablets. Exam: AS murmur

LCC2. 55 female with fatigue and tiredness and generlized bodyaches. On examination i think helitrope rash but not sure. I made it dermatomyosistis.

******
Pakistan 28.2.24
Lcc1
60 years old woman with htn 4-month hx of
Shoulder pain & lower back pain with fever
Likely pmr, tender to touch

Lcc2 : 35 years with persistent fever and had a murmur seems IE

Communication 1
Seizure on suspected tumor on ct brain on temporal
Councel for mri.

Comm 2
Myotonia congenita consultation

Abd .just spleen
No other findings (?axillary Lymph node enlarged)

Chest : effusion

Cvs: MR with MS

Neuro : UL examination, fasciculations, LMN signs, all sensory modalities except joint proprioception lost

****
DIET 1 2024 PINDI :

One long case was dysphagia
one long case was COPD with pulmonary hypertension.

Short case Abdomen ..Liver transplant
Short case Respiratory..lobectomy/Pneumonectomy
Short case neuro...LMN command was upper limb and it was proximal myopathy pt was having CVP line in Neck he was myasthenia gravis patient middle age patient with no thymoma scar.
CVS short case was HOCM

communication 1...APKD
Communication 2....Angry patient son was concerned regarding steroid induced psychosis ie steroids was given in suspicion of GCA...However the consultant proven that its not the diagnosis and pt was stopped from steroid and then admitted to the hospital.

*****
2- 78 years female with CAD Hx now Angina at rest, CABG planned and patient refused for it as explained by the interpreter.
Son insisted on signing the consent and asking if he can explain this to the patient instead of an interpreter. and was angry why we talked to the patient about surgery without involving him first.

How to approach it?

Case2: BCC
A 59 year old male with Pain RHC. All vitals are normal except RR 24.
Straightaway after localisation I started GI questions. And the surrogate said: yes jaundice.
Then I asked about itching and pale bowel work.
Weight loss + low appetite.
And i got the DX With past hx of HCV.

On exam:
Dark pigmentation + Ascites +hepatomegaly +deep jaundice + scratch marks +shiny nails.

No asterixis ,no hepatic stigmata.

Surrogate:
What is he suffering from ? I draw and told could be obstruction in channels of liver.

Is HCV recurred ? Probably.
Is it cancer? Likely

Examiner DDX
Pri 2nd in liver
Periampullary tumour (panc ca)
MetstoCbd

Os:
Investigation? :1st mentioned MRCP and ERCP.
Then he said y ERCP? i said Both Dx and rX.
Then he asked, if the lesion is in the pancreas then what ix? i said EUS +/-Bx
Then RX:
He asked if its panc ca, what single Rx? Isaid Depends whether primary or mets.
He said if mets? Then i said ERP +- stent
Bell Dungggggggg...

Case2:
CVS:
Regularly Irregular AF
Tapping apex
Mid diastolic murmur
Ddx:
MS+ AF (i checked directly pronator drift after i find he's In AF)
TS
Investigations and RX. Causes of MS? RX of MS?

CNS: young boy LL exam
UMNL +dorsal +cerebellum.
I offered Gait, UL, Spine ,Cranial nerves ,fundus.
So
Ddx
Demyelination (MS) ,Degeneration (FA)
They started viva on MS .... Went well.

Case
3:
Communication :40y old salesman DM with CX (nephropathy /retinopathy) talk to son.

Started well
Explained each and every thing : Risk of very high blood sugar.
Concern: I can't Take insulin plz? I Explored Why????
He said my cousin got unconscious with that.

Concern: alternative to insulin ?
Concern: i'm depressed (involved OHP and physical Trainer to give a proper relaxation exercises good for DM and your mood)

Concern:
Do u force me to take this injections??No Buddy. (who the hell we are? we are Common men) It's your right to choose which rx u want buttttttt the best Rx for u at this moment is Insulin as advised by the consultant. We respect your wishes.

Do you smoke ? Stopppppp. Alcohol? No.
Drive : well. may i know do u know about low sugar signs?: common, this, this, this..
I will refer you to a sugar specialist nurse to teach you all the things regarding injections ,doses, techniques, routes, timings. Otherwise inform DVLA.Ok?

And please Have a good follow up with Sugar clinic, Kidney clinic ,Eye clinic.

Leaflets browser websites. tata..

Abdomen:
Young male overall yellow tinged. When I saw the nails it was shiny.
Eyes: lemon ting.
Hepatomegaly 6cm.
Faded Scratch marks.
Ddx: Acute hepatitis especially Cholestatic phase of A and E ,
Stone
Stricture
Worms
Pbc psc

Then he asked where is obstruction? isaid extrahepatic
hepatitis esp

He said how this is acute? I said it is a possibility ...
Then he said how to IX?
CBC
Total bili / direct bili/ indirect ALP
PT alb Inr
Viral profile US abdomen

Then he again asked how acute hep? Hahahah i said sir its called Cholestatic phase of Hep A and E .

How to RX: MDT
Rx the cause
Tata

LCC : 50y old male with LoC. Vitals Normal

Imade all Ddx outside of syncope / Tia/ hypoglycemia / seizure
+family hx of stroke ,HTN.
Job- driver: STOP and inform DVLA to access youuuu
Surrogate:
Its seizure? Unlikely
Its heart ;can be v have to do test to find out
Will it happen again: can be

DDX:
Cardiac syncope
Reflex syncope (which one: i said Vasovagal)
Then he gone to vasovagal

Tilt table RX

Communication : severe ischemia. Consultant advised CABG. Written in scenario
Patient refused just 2 words (a bit hiddenly)
Son:
Was very fazul and angry Frightened facies
Have you ever heard abt CABAg ? draw even the diagram? He said no need to tell me. I'm very depressed.
I was silent no. then started why are you depressed? Why not? I'm because of my mom.
(Common yar) we are here to help your mom.
No NO No.
Surrogate: why did you inform my mom ?
Donkey it's her right to be informed & we may needs consent for procedure
And it's in the best interest of her. Otherwise she will go into life threatening conditions. she may have a severe attack and unfortunately.
if not treated she may die.

Surrogate : whatttttttttttttt???? Yes i'm so sorry for that
Surrogate: ok ,tell me what to do? i will tell everything to my mother
(Who the hell are you?)
We Can arrange another meeting for your mom ,even my consultant too plus The heart team. are you?

Why not me? Well we will ask ur mom if she wants u in meeting no issue for us.

Duzz bell dungggggg

Short case :Respiratory : patient with SOB. Seen the command 3 times as iwas puzzled

Thick hairy chest
Just find consolidation in upper part
And fine crackles in lower part which was not changed with cough
I didn't find any effusion
Ddx :

Pul fibrosis
Consolidation, Cavitation.
Then he asked my causes of Fibrosis and Rx. that's it.
Other friends mentioned effusion a s well.

*****

Islamabad 27-01-24

LCC1
young male with LOSS OF CONSCIOUSNESS
hx of Vasovagal syncope

LCC 2
Pain in Right Hypochondrium
Cholangio Ca

Abdominal
Hepatomegaly with jaundice

CVS
MITRAL STENOSIS with PH

RESP
consolidation with effusion

CNS
MULTIPLE SCLEROSIS

Communication
1- Uncontrolled Diabetes not willing to take Insulin injection

2- 78 years female with CAD Hx now Angina at rest, CABG planned and patient refused for it as explained by the interpreter
Son insisted on signing the consent and asked if he could explain this to the patient instead of an interpreter and was angry. why we talked to the patient about surgery without involving him first.

*****

Station 1
Bronchiectasis with dextrocardia

Communication
Advanced COPD DNR

Station 2
Ankylosing spondylitis on biological therapy and methothroxat
Hx of tb exposure and travel to thailand

Reactivation of tb
Lymphprolifertive disoder
HIV

Station 3
Neurology
Ms

Cardiology
Diastolic murmurs
Could be Ms or Ar

Station 4
Abd
Massive hepatomegaly

Communication
Parkinson's dementia
With miss Dose of drug during hospital admissions basically it was drug error

Station 5
Chest pain
Hx of naproxen abuse
Osteoarthritis

On examination
MR

Ddx
Angina
Pud with gord
PE

****
Communication

K/c parkinsons developed pneumonia and admitted in ward and for 3 days now confused and dizzy as anti park medications were missed
Error

Communication 2.
K/c old came with pnemonia already on maximum treatment consultant decided he is already on oxygen n max treatment so tell patient about dnacpr and comfort care
Premorbid he was bed bound at home and max o2 support as wel

Lcc1 previous A.spodylitis on mtx came with fever and hemoptysis for 1 month ,father have tb as wel

Ddx TB reactivation or any other infection

Lcc2 chest pain 2 episode acute

******
Pakistan morning diet1 26.1.24

Comm
Penicillin allergic given penicillin and now she has pneumonia, delirium and error.

Abdo. ADPkd. bilateral ballotable mass. fistula with recent needling in HD bruising whole body

Lcc
Hx of RA, young. swelling in his left knee.
Excluded Reactive arthritis/septic also
RA.

Lcc2
2 days fever back now fine.
hx of neck pain, no stiffness.
1 day hx unable to close eye
LMNL facial palsy.
Ex. Not a febrile, travelled to the US a few days back.
Fever high grade took paracetamol & resolved.
Lyme disease may be.
Fx father have weakness of arm and legs like ms
Concern . Is it going to die ?
Is going to be better
Chest dec breath sound lower right chest over with treachery shift to affected side.

Comm2:
Medication error

Known dM came in ward with pneumonia .dr prescribed short acting insulin was written 20 unit twice a day of short acting on got hypoglycemia 3rd post admission day got that at home mixed 20 unit twice a day pharmacist told he should be taking mixed rather than short acting
Concerns:
What could happen?
What will be long term effects?

Cvs. Systolic murmur with diastolic murmur as well. mixed aortic valve disease

Neuro:
UL : parkisnons disease

****
Rawalpindi

1-consultation: polyuria, polydipsia. it was probably DI
2- Consultation: patient on steroids developed lower backache. History of TB in the past. most likely osteoporosis fracture, TB discitis.

3- MR with TR
4- Bilateral foot drop
5- hepatosplenomegaly (huge masses)
6- chest bilateral crackles (no clubbing) , some said ILD, looks were that of COPD

7- counselling of myotonic dystrophy
8- Counselling of son , mother developed Aki with gentamicin due to medical error.

****
Pakistan morning 24.1.24

Bcc 1 CABG 7 years back
Recurrent epigastric pain since few months
Dx is chronic pancreatitis alcohol n TG

BCC 2 weakness
Dx MCTD

NEURO Prox myopathy
CVS MR with fine crackles
Chest ILD with Rh arthritis

Abdomen
Right sided burn like scar with no mass beneath it but left sided Nephrectomy scar n avf in left hand

Communication 1
Leg Cellulitis was treated in hospital with iv abx
Junior dr changed iv cannula with out gloves n he got MRSA infection in arm as well
So dealing angry patient

Communication 2
Young lady took gliclazide
Was managed with dextrose
Mx team decided to take mood dr review for her
She was angry n was will DAMA as mood dr was involved without her consent

****
pakistan 24.1.24

Abdomen..LT

Respiratory..lobectomy/Pneumonectomy
Short case neuro...LMN signs: MG with Thymectomy scar
command was upper limb and it was proximal myopathy pt was having CVP line in Neck he was myasthenia gravis patient middle age patient with no thymoma scar.
CVS : HOCM

communication 1...APKD

Communication. 2....Angry patient :son was concerned regarding steroid induced psychosis ie steroids was given in suspicion of GCA ...However the consultant proved that it's not the diagnosis and pt was stopped from steroids and then admitted to the hospital.

Consultation scenarios
dysphagia.
COPD with pulmonary hypertension.

****
Pakistan 24.1.24
LCC: Back pain that is worse at rest.
Inside : Psoriatic arthritis

LCC: Progressive weakness.
Inside : MS. Ataxic gait, past pointing, INO.

CvS: MVR. Systolic murmur.
Resp : scar with pneumonectomy / lobectomy.
ESRD - renal transplant with fine tremor.
Neuro.- left hemiparesis with UMN VII CN palsy .

Communication 1: angry daughter whose father developed amiodarone induced lung fibrosis.

Communication 2: Son of a patient who has bladder Ca. now presented in ER with drowsiness and deranged Rfts, treatment nephrotomy planned.
****
Islamabad 27-01-24

LCC1
young male with LOSS OF CONSCIOUSNESS
hx of Vasovagal syncope

LCC 2
Pain in Right Hypochondrium
Cholangioca

Abdominal
Hepatomegaly with jaundice

CVS
MITRAL STENOSIS with PH

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consolidation with effusion

CNS
MULTIPLE SCLEROSIS

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1- Uncontrolled Diabetes not willing to take Insulin injection

2- 78 years female with CAD Hx now Angina at rest, CABG planned and patient refused for it as explained by the interpreter
Son insisting on signing the consent and asking if he can explain this to the patient about instead of interpreter and was angry why we talked to the patient about surgery without involving him first.

******
Pakistan 24.1.24
Commu- son of a PT who has bladder CA now presented in ER with drowsiness and deranged Rfts, treatment nephrotomy planned
Commun- angry daughter whose father developed amiodarone ass lung fibrosis
Neuro - left hemiparesis with left UMN facial nerve
Abd- ESRD with Renal transplant and fine tremors
Resp scar with pneumonectomy /lobectomy
cVS - MVR with systolic kurmur
BCC- progressive weakness -inside MS in a PT who has ataxic gait , INo and past pointing
BCC- - backache that gets worse with rest , inside psoriatic arthritis

****
✒️✒️✒️✒️
Cns: MS
Pulmo: Copd
Abd: hepatosplenomegaly
Cvs: valve replacement with MR
(Not sure MVR or AVR)

Consultation:
Parkinsons
Tuberculous meningitis (hiv patient)

Communication:
Hep. B scenario
****
Bcc 1 CABG 7 years back
Recurrent epigastric pain since few months
Dx is chronic pancreatitis alcohol n TG

BCC 2 weakness
Dx MCTD

NEURO Prox myopathy
CVS MR with fine crackles
Chest ILD with Rh arthritis
Abdomen
Right sided burn like scar with no mass beneath it but left sided Nephrectomy scar n avf in left hand

Communication 1
Leg Cellulitis was treated in hospital with iv antibiotics. Junior dr changed iv cannula without gloves & he got MRSA infection in arm as well. So dealing angry patient

Communication 2
Young lady took gliclazide
Was managed with dextrose
Mx team decided to take mood dr review for her.
She was angry n was will DAMA as mood dr was involved without her consent

******
Rwp morning 23/01/24

Cardio..... Mitral stenosis
Resp....scar with effusion
NEURo.... pure motor neuropathy GBS
Abd..... jaundice with hepatosplenomegaly

Consultation 1...
Shortness of breath in male patient with high BP in vitals outside 180/110
Significant hx of DM HTN and asthma on steroids significant family history if stroke and high bp
Ddx
OSA sec to cushing
cardiogenic asthma
Metabolic syndrome

Consultation 2..
Weakness of all 4 limbs
Surrogate told about progressive weakness with fasciculations
Inside MND

Communication 1...
Scenario of DM with hypoglycemia unawareness. on bisoprolol as well.

Communication 2...

Pckd bbn and further plan

****
Pakistan morning diet1 26.1.24

Comm
Penicillin allergic given penicillin and now she has pnemonia diliruim and error

Abdo. Pckd bl balotable mass.fistula with recent needling in HD bruising whole body

Lcc
Hx of RA young swelling in lt knee
Excluded Reactive arthritis/septic also
Ra

Lcc2
2 days fever back now fine .hx of neck pain no stiffness
1 day hx unable to close eye
Lmnl facial palcy
Ex. Not febrile traveled to US few days back.
Fever high grade took pcm resolved
Lyme disease may be
Fx father have weakness of arm and legs like ms

Concern :.
Is it going to die ?
Is going to be better

Chest dec breath sound lower right chest over with treachery shift to affected side

Comm2:
Medication error

Known dM came in ward with pnemonia .dr proscribed short acting insulin was written 20unit twice a day of short acting on got hypoglycemia 3rd post admission day got that at home mixed 20 unit twice a day pharmacist told he should be taking mixed rather than short acting
Concerns: what cud happen
What will be long term effects

Cvs. Systolic murmur with diastolic murmur as well mixed aortic valve disease

Neuro:
UL parkinson's disease

******
Islamabad 27-01-24
LCC1

young male with LOSS OF CONSCIOUSNESS
hx of Vasovagal syncope

LCC 2
Pain in Right Hypochondrium
Cholangioca

Abdominal
Hepatomegaly with jaundice

CVS
MITRAL STENOSIS with PH

RESP
consolidation with effusion

CNS
MULTIPLE SCLEROSIS

Communication
1- Uncontrolled Diabetes not willing to take Insulin injection

2- 78 years female with CAD Hx now Angina at rest, CABG planned and patient refused for it as explained by the interpreter
Son insisting on signing the consent and asking if he can explain this to the patient about instead of interpreter and was angry why we talked to the patient about surgery without involving him first.

****
Communication 1:medical error insulin overdose given to pt at hospital

Communication 2:AF.TIA counselling about anti coagulation

Long clinical consultation 1:hand pain ,obese,OSA,= carpal tunnel

2:Female with fatigue SOB=thalassemia,hepatosplenomegaly pale

Neuro: proximal myopathy
cardio: ESRD on hemodialysis. MR.
Chest : pulmonary fibrosis
Abdomen : HSM, ascites

****
Islamabad 27-01-24

LCC1
young male with LOSS OF CONSCIOUSNESS
hx of Vasovagal syncope

LCC 2
Pain in Right Hypochondrium
Cholangioca

Abdominal
Hepatomegaly with jaundice

CVS
MITRAL STENOSIS with PH

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CNS
MULTIPLE SCLEROSIS

Communication
1- Uncontrolled Diabetes not willing to take Insulin injection

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******
DIET 1 2024 PINDI :

One long case was dysphagia
one long case was COPD with pulmonary hypertension.

Short case Abdome..LT
Short case Respiratory..lobectomy/Pneumonectomy
Short case neuro...LMN command was upper limb and it was proximal myopathay pt was having CVP line in Neck he was mysthenia gravis patient middle age patient wid no thymoma scar.
CVS short case was HOCM
communication 1...APKD
Communication 2....Angrey patient son was concerned regarding steriod induced psychosis ie steriods was given in suspicion of GCA...Howerever the consultant proven that its not the diagnosis and pt was stopped from steriod and the admitted to the hospital.
****

[11/05, 4:17 pm] +92 324 0580669: Rwp morning 23/01/24

Cardio..... Mitral stenosis
Resp....scar with effusion

NEURo.... pure motor neuropathy GBS
Abd..... jaundice with hepatosplenomegaly

Consultation 1...
Shortness of breath in male patient with high BP in vitals outside 180/110
Significant hx of DM HTN and asthma on steroids significant family history if stroke and high bp
Ddx
OSA sec to cushing
cardiogenic asthma
Metabolic syndrome

Consultation 2..
Weakness of all 4 limbs
Surrogate told about progressive weakness with fasciculations
Inside MND

Communication 1...
Scnerio of DM with hypoglycemic unawareness on bisoprolol as well

Communication 2...
Pckd bbn and further plan
[11/05, 4:17 pm] +92 324 0580669: Pakistan evening 23 jan diet 1/24

Cns: MS
Pulmo: Copd
Abd: hepatospleenomegaly
Cvs: valve replacement with MR
(Not sure MVR or AVR)

Consultation:
Parkinsons
Tuberculous meningitis (hiv patient)

Communication:
Hep. B scenario
[11/05, 4:17 pm] +92 324 0580669: Pakistan evening 23 jan diet 1/24

Cns: MS
Pulmo: Copd
Abd: hepatospleenomegaly
Cvs: valve replacement with MR
(Not sure MVR or AVR)

Consultation:
Parkinsons
Tuberculous meningitis (hiv patient)

Communication:
Hep. B scenario
[11/05, 4:17 pm] +92 324 0580669: *Pakistan morning 24th jan 24*

Communication 1
Leg Cellulitis was treated in hospital with iv abx
Junior dr changed iv cannula with out gloves n he got MRSA infection in arm as well
So dealing angry patient

Communication 2
Young lady took gliclazide
Was managed with dextrose
Mx team decided to take mood dr review for her
She was angry n was will DAMA as mood dr was involved without her consent
[11/05, 4:17 pm] +92 324 0580669: *Pakistan morning 24.1.24*

Bcc 1 CABG 7 years back
Recurrent epigastric pain since few months
Dx is chronic pancreatitis alcohol n TG
BCC 2 weakness
Dx MCTD
NEURO Prox myopathy
CVS MR with fine crackles
Chest ILD with Rh arthritis
Abdomen
Right sided burn like scar with no mass beneath it but left sided Nephrectomy scar n avf in left hand

Communication 1
Leg Cellulitis was treated in hospital with iv abx
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[11/05, 4:17 pm] +92 324 0580669: *pakistan 24.1.24*

Abdomen..LT
Respiratory..lobectomy/Pneumonectomy
Short case neuro...LMN signs: MG with Thymectomy scar
command was upper limb and it was proximal myopathy pt was having CVP line in Neck he was myasthenia gravis patient middle age patient wid no thymoma scar.
CVS : HOCM
communication 1...APKD
Communication.

2....Angry patient :son was concerned regarding steriod induced psychosis ie steriods was given in suspicion of GCA...Howerever the consultant proven that its not the diagnosis and pt was stopped from steriod and the admitted to the hospital.

Consultation scenarios
dysphagia.
COPD with pulmonary hypertension.
[11/05, 4:17 pm] +92 324 0580669: *Pakistan 24.1.24*
Commu- son of a PT who has bladder CA now presented in ER with drowsiness and deranged Rfts, treatment nephrotomy planned
Commun- angry daughter whose father developed amiodarone ass lung fibrosis
Neuro - left hemiparesis with left UMN facial nerve
Abd- ESRD with Renal transplant and fine tremors
Resp scar with pneumonectomy /lobectomy
cVS - MVR with systolic kurmur
BCC- progressive weakness -inside MS in a PT who has ataxic gait , INo and past pointing
BCC- - backache that gets worse with rest , inside psoriatic arthritis
[11/05, 4:17 pm] +92 324 0580669: *Pakistan morning diet1 26.1.24*

Comm
Penicillin allergic given penicillin and now she has pnemonia diliruim and error

Abdo. Pckd bl balotable mass.fistula with recent needling in HD bruising whole body

Lcc
Hx of RA young swelling in lt knee
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Ra

Lcc2
2 days fever back now fine .hx of neck pain no stiffness
1 day hx unable to close eye
Lmnl facial palcy
Ex. Not febrile traveled to US few days back.
Fever high grade took pcm resolved
Lyme disease may be
Fx father have weakness of arm and legs like ms
Concern . Is it going to die ?
Is going to be better
Chest dec breathsound lower rt chest over with treachery shift to affectide side

Comm2:
Medication error

Known dM came in ward with pnemonia .dr proscribed short acting insulin was written 20unit twice a day of short acting on got hypoglycemia 3rd post admission day got that at

home mixed 20 unit twice a day pharmacist told he should be taking mixed rather than short acting
Concerns: what cud happen
 What will be long term effects

Cvs. Systolic murmur with diastolic murmur as wel mixed aortic valve disease

Neuro:
UL parkisnons disease
****
DIET 3 2023 PAK*

St 1 abdomen : splenomegaly
Resp: Pneumonectomy
St 2..tiredness after 18 months of delivery weight gain low mood. Dd hypothyroidism, sheehan syndrome ,depression, pregnancy etc

St 3. Cardio. MR with pulmonary HTN and IE
Neuro. Cranial nerve 6 7 9 10 11 lateral medullary syndrome no.one exactly know the findings and diagnosis

St 4 Post MI came and wanted to decrease medicine ...counselling about post MI life style and medication assessment

St 5 bcc 1. Headache SAH/BIH/CVST

Bcc 2. Medication induced peripheral neuropathy,pt was on TB medication

*****
📚Pakistan today
Cc
Bleeding per rectum
Inside acromegaly

30 yes bleeding per rectum
Haemorrhoids before so I don't
Ist episode red I have
Back pain as well

Inc with activity walk
No any other symptoms red flags

Headache yes
Diclo for joint pain
Change in hand and feet size yes

Prognathism
Macroglossia

No osa symptoms
Concerns
Wud it be reversible?

Long viva
Mgt
Treatment
After resection he will u manage

Cc
Sob and cough 6 months
Wt Loss 6 kgs
Clubbing
Yellow sputum
Ps: clubbing ,Palmar erythema,flapping tremors,coarse creps in lung

Ddx ca lung/ bronchiectasis/ ild / copd

Communication
1, patient came with heart attack done PCI ,during that undergone cardiac arrest and diet bbn to wife

2, the patient has got suspension of lung ca. bbn and tell abt ct and further mgt.

Chest lobectomy
Cvs MR
Neuro ulnar nerve palsy
Abdo renal transplantation

💠💠Pakistan : diet 3/2023♦♦♦
Communications
Pt 30 yr old pilot tall slim ex smoker with spontaneous pneumothorax resolved now but residual air is there and pt has had cxr 6 hrs back now still waiting to leave as he was told he needs review from dr before going for flight pt is angry address concerns .

Communication
Pt 30 yr old had hemetemesis and malena one episode he is on nasids for ch back acke he was nop for endoscopy but endoscpy cudnt b done coz of some emergnecy in endoscopy room
Pt is still npo and waiitng for you to speak as he is not happy about this delay and wants dama

Consultation
1 ...Smoker ..long term sob cough for years now hemoptysis .....

2… Pt with vague headaches and confusion episodes for 3 months .

Inside : patient was hypothyroid look as well as hypothyroid for 8 yr well controlled and a smoker and on thiazide diuretics .
Sodium 126 … So it was SIADH ... 2ndary to hypothyroid . Thiazide . So that's all what I said .

Short cases ....
AVR
MS
ILD vs bronchiectasis (pt had RA hands)
Cld with portal HTN .

DIET-3/23 *RAWALPINDI*
Counselling:
1- 72 yrs old came with stroke, thrombolysis given after consent by patient, pt had massive ICH, GCS: 3, neurosurgeons said he's unfit for surgery, counsel son he's going to die soon.

Son is asking why he wasn't informed and asked before thrombolysis.

2- A young female came with fever, headache, photophobia, skin rash. U r suspecting meningitis, Explain your suspicion and counsel for LP.

Resp: Bronchiectasis with lower lobectomy
CVS: MR
Abdomen: Renal transplant with pain abdomen (was asking for cause)
CNS: asymetrical Spastic paraperesis, clonus, sensations intact

Consults:
1- middle age man with nose bleed. On history no bleed from anywhere else, pt has cough at times productive, no renal symptoms. On ATT for a few months but noncompliant.
On exam, saddle nose and crackles on chest exam.

Made GPA my first D/D, then TB.

2. Young male with 1 month h/o fever and cough mostly dry. O/E, fever, HR 100/min, Resp rate: 20, BP: 100/60.
Treated for Pulm TB 2 years ago.
History- recent travel to Punjab, no other info known by the surrogate
High risk behaviour before- 2 casual partners plus IV drug abuse in past.
O/E: wasted, had coarse crackles on chest exam.
D/Ds I gave were:
- HIV with PCP
- Reactivation of TB
- infective endocarditis

[**********
📚Pakistan Diet 3:
Consult
Aortic stenosis

Systemic sclerosis

Comm
Mislabeling of hiv test
Counseling for thrombolysis and suspected cancer

Mitral stenosis
Sensory ataxia?
Hepatomegaly
Upper /lower lobectomy?

DIET 3 2023 RAWLPINDI PK

🩺: Communication
1. Patient of infective endocarditis, wants to go home, u have to convince him to stay in hospital for iv antibiotics

CLINICALS :

AR,
Liver transplant,
Thoracotomy,
LMN lesion,

LONG CONSULTATION :
cirrhosis (consult), Scleroderma (consult)

🩺: Communication 2, patient of bulbar palsy, have recurrent aspiration, one test that is video fluoroscopy has done, u have to tell about the video fluoroscopy result and tell him other methods of nutrition ie NG tube and PEG tube…

******
DIET 2 2023 PAK

St 1
Pleural effusion
Hepatomegaly

St2 recurrent hypoglycemias. Pt was known case of DM-1 sich 15 years, had diabetic nephropathy and diabetic retinopathy.

St3
MS
MND

St4
Insulin wrong dose given
Fussy surrogate, asking same things again and again even after the explaining well.

St5
Bcc1: Pheochromocytoma in the background of neurofibromatosis.

Bcc2: Stroke. Pt still had weakness.
MVR one year back on warfarin dint followup with INR clinic since 3 months.

*****
Pakistan today cases
St 4
SAH want to DAMA , but she convinced at end for staying in hospital and for LP

St 5

Grittiness of eye and sitting standing issue ➡️ thyrotoxicosis

Swallowing problem ➡️SS

St 1
Fine crackles at at Bases ILD
Abdomen :: i said normal but some says hepatomegaly

Station 2
Complaints: vomiting / Nausea

Lymphoproliferative disorder post renal transplant sec to medications

Low WBC
Low plt
High ALT
Normal pancreatic level …

Complains vomiting / loose non bloody diarrhoea

Station 3
Peripheral neuropathy
Cardiac : to me it’s mitral stenosis

Diet 2 2023
Rawalpindi

station 1
bronchiectasis
polycystic kidney

station 2 occupational asthma

station 3
mr
lateral medullary syndrome

station 4
medical error

station 5

Takayasu

CLD / HCC
*****
St1. Rt lateral thoracotomy scar…
Hepatomegaly,

St 2 palpitations with family Hx

St 3. Mitral stenosis
spastic paraparesis with no sensory level gabs DDs

St 4 Pt had pharyngeal pouch on endoscopy and had barium swallow
2 wks back that had pharyngeal pouch that was missed so explanation of diagnosis and need for further inv .. plus med error

St 5 psoriatic arthritis on methotrexate having SOB fatigue and cough,

St 5 b
Young man with haematuria and epistaxis gave
D/ Ds wingers GBM and vasculitis

******
St4
Suicidal assesment
Nurse took gliclazide

Medical error
Missed drug dose causing epileptic seizures

Pharyngeal pouch missed on barium swallow now done endoscopy and got that.

Complication of procedure

Esophageal perforation during ogd

Disease explanation
Chrons and its treatment

_____
St 1 pneumonectomy . Polycystic kidney disease

St 2 Pots Syndrome

St 3 spastic paraplegia with lost dorsal column . VSD

St 4 ulcerative colitis management and diagnosis

St 5 wegener's granulomatosis .
Hepatic enceph

****__
St2 :

Pots

Palpitation

Poorly controlled asthma ie occupational

RA with sob
On biologics
No TB contact
Acute inf

Wt loss known case DM1

Chest pain IHD,GERD

Poorly controlled asthma recently ie churg strauss

*****___
 St4
Suicidal assesment
Nurse took gliclazide

Medical error
Missed drug dose causing epileptic seizures

Pharyngeal pouch missed on barium swallow now done endoscopy and got that.

Complication of procedure

Esophageal perforation during ogd

Disease explanation
Chrons and its treatment

******_
St3

Cvs
Mixed lesion Ms,Ar

Neuro
Ptosis with fixed dilated 3rd nerve palcy

St4
mom admitted
With UTI previously was on parkinson's 3 years ago now came with disability..

Bcc1
65 years male with wife on train station and rush and lost consciousness

On ex Aortic stenosis

Bcc2 young male facial rash 6 months.
hx early morning joint pain and stiffness with active synovitis.

Treated case of TB list of drugs
And having list of medications
Ddx : SLE

St1 lat thoracotomy scar with pleural effusion drain scars as well.

Hepatomegaly with massive splenomegaly
Striae over abdomen and ascites

St2 26 years old
Dm1 with hypoglycemia episodes
Well educated and learned abt insulin

Ddx
Diabetic autonomic neuropathy
Addison
APS2

Diet 2 Cases :

DIET 2 2023 RAWALPINDI

St 1
Chest lat thoracotomy scar with pleural effusions and drain scars

Abdomen . No finding except jaundice

Neuro vague signs in young man
1 side lmn and other side umnl signs with no sensory or cerebellar
So gave ddx of mixed lesion

St2
40 years old male with Right sided chest pain ....6 weeks
Off and on
4 to 5 times a day burning in character and relieving with rest
BP 159/90
Fx sudden death of brother at age of 40
Job heavyanual work
Ddx I gav ACS angina
Hocm

St5
Bcc1 haematemesis and malena
1 episode 32 to 4 tea spoons
Fresh blood
Dx said once in month
Patient was citric,palmer erythematosus
So ddx I gav v.bleeding
Nsaid induces

Bcc2
DM1 with dizziness
Inside pt gav hx of Dzzi when standing from sitting
Px had pnemonia 10 days back n then this dizziness started

Ox surgery . Some kidney tumor which was secreting some hormone
Dx insulin
Patient having pigmentation all over and inside mouth.
Gav ddx of addison

St4 nurse took gliclazide
Concerns will u breach confidentiality?

Hepatomegaly
Pneumonectomy
Mvr
Medical error forgotten dose in a known epileptic patiant leading to fits
Hypothyroidism due to iodine ttt
Recurrent fever + travel history

Station 1
-RA with ILD
- Splenomegaly

Station 2
-RA history with SOB for 3 days

Station 3-
- CABG + AVR
- oscillating nystagmus

Station 4
Post EGD dilatation leads to perforation in achalasia pt
Counsel son regarding what has happened and convince not to take patient home

Station 5
Bcc 1 loose stools , hyperthyroidism
Bcc 2 confusion, collapse , cause (cardiac arrhythmia)

Aoa. These are the individual findings. Real findings could be different. It's just a personal experience.
Station 1: Resp: Mild clubbing, B/L basal coarse crypitations changed on coughing D/D Bronchiectasis, B/L pneumonia.
Abdomen: B/L renal mass D/D APCKD, B/L hydronephrosis , Renal CA . Had time so, also checked for Eye and pronator drift .
Station 2: 29 male K/O Asthma 10 years . Now from 3 months had wheez , cough and SOB , *Job changed 3 months back . D/D Occupational asthma.
GERD .
Station 3: CVS: pansyatolic murmur radiating to axillaD/D : MR , TR and VSD .
Neuro : LL exam. Pt power was decreased in left leg distally. Reflexes absent . Sensation reduced in Right leg , Left leg heel shin abnormal .D/D : , Stroke (PICA). CIDP , difficult Case 😉.
Station: 4 , Known case of epilepsy.Well controlled from last 10 years . Taking levitracitram. Yesterday admitted for orthoplasty. He was asked to b NPO from 6 am morning by the pre Assessment team . He missed the dose Levitracitram . Had seizure in the evening.Pharmacyst told him that he should not missed the dose. Now he is informed by the medical team to inform the DVLA and he needs to stop the driving for 1 years .
Concerns: 1 , Who is responssible for my missed dose .
2 : I drive daily for my work , I cannot stop driving.

3 : Is there any compensation becoz I would not drive for 1 year.
Station:5 , BCC1, Young male feeling fatigue on exertion .
On Hx he said having left arm pain. ESR raised .(It was a clue but I missed)🤐
D/D Vasculitis - Takayasu arthritis. Aortic valve disease .it was a difficult case . I could not diagnose Takayasu. I said Aortic valve disease 😔.
BCC-2: 55 yrs old male having progressive abdominal distension.
On Hx : Hx of HBV 5 YEARS.
Hx of pulmonary T.B
Pt had abd pain so asked the examiner for examination.He stopped. I Offer for Liver , slpeen , shifting dullness and DRE .
D/D : HBV related DCLD .
 HCC .
Abd T.B
Viva was on DCLD .
 Thank you . ☺

Rawalpindi Today

Station 1
-RA with ILD
- Splenomegaly

Station 2
-RA history with SOB for 3 days

Station 3-
- CABG + AVR
- Oscillating nystagmus

Station 4

Post EGD dilatation leads to perforation in achalasia pt. Counsel son regarding what has happened and convince not to take the patient home.

Station 5
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Bcc 2 confusion, collapse , cause (cardiac arrhythmia)

today cases 1/23
St 4
SAH want to DAMA , but she convinced at end for staying in hospital and for LP

St 5
Grittiness of eye and sitting standing issue ➡️ thyrotoxicosis

Swallowing problem ➡️SS

St 1
Fine crackles at at Bases ILD

Abdomen :: i said normal but some says hepatomegaly

Station 2
Complaints: vomiting / Nausea

Lymphoproliferative disorder post renal transplant sec to medications

Low WBC
Low plt
High ALT
Normal pancreatic level …
Complains vomiting / loose non bloody diarrhoea

((Station 2 , I believe D/D
will be

Post Transplant Lymphoproliferative Disease
Calcineurin Inhibitor toxicity
Infection like TB
Other cancers with Mets))

Station 3

Peripheral neuropathy

Cardiac : to me it’s mitral stenosis

*****

I am sharing my exam experience. I feel my exam was not good. I am just writing what I felt....

Apart from me, Other 4 candidates were from South India. They said they got puzzled too..especially at Neuro station...

St1 :

Res : Emaciated elderly pt, percussion dull breath sound diminished, from rt 3rd ICS to downwards, same on back, trachea shifted to right...

I said mass lesions as lung malignancy... Regarding trachea i said i couldn't appreciate bronchial breath sound / any added sound , asked what would you think? I said collapse/ fibrosis. then inv+mx

Abdomen : Shifting dullness positive + b/l leg edema

DCLD, intra abdominal malignancy / infection... Inv+ mx

St: 45 yr old lady e sudden dizziness, spinning on neck movement, only once happened this morning, having a high stressful job for 20 yrs, having anxiety + depression, drug only sertraline 50 mg for 1 yr, ..f/h/o-CVD. Her BP - 160/ 90 mmhg....

I said, drug induced, Vertebrobasilar ischemia / TIA, cervical spondylosis.....regarding dd + Inv

St -3

CVS : your boy e AS+AR

Neurology : Difficulty in walking, examining the sensory system...

I found nothing on the sensory system... examined upper then ...checked gait... Said Parkinsonism, said some dd....(in this station everyone was puzzled) don't know what they actually wanted.

St4:

End stage alcoholic liver disease and renal function deterioration. Treating team doesn't think liver transplant would work now. Want to carry on with ongoing mx. Non invasive procedures to be done. .councell regarding resuscitation mx + other concerns..

(Both british examiners asked me one question, do you practise that in India?. I said, i am from Bangladesh Mam, i have no idea what happens in India 😃, then they laughed)

BCC-1 Psoriasis (Surrogate was puzzling more than the pt!)

BCC-2 Parkinson's diseases e Cardiac problem - British examiner took this

(Surrogates are probably med students here., they are not properly trained up.. I had to ask 2-3 times for a particular thing....he doesn't know what water work is! The examiner came & told him to tell me!.. Took lot of time there

******
Diet 1 2023 Lahore

1. Resp = lung crepitation not changing with cough with joint deformity ILD with RA
Abd = mass in right upper abd hepatomegaly for differential

2. History = back pain with history of trauma, inflammatory type pain. Ankylosing spondylitis

3. BL lower limb UMN lesion with sensory loss up to umbilicus —- could not do cerebellar or gait —- spinal cord lesion, demyelination tumour infection

4. On Methotrexate given trimethoprim for UTI —— bleeding 2 to pancytopenia

5b. Joint pain, skin tightening mouth opening decreased no pul complication like fibrosis or pul hypertension —— systemic sclerosis

CVS station AF with MR for me as I got systolic murmur at apex but could not appreciate axillary radiation but others were saying diastolic murmur so MS

****
St 1
Pneumonectomy + bronchiectasis
Jaundice+hepatomegaly

St 2
30 year old female with syncope

St 3
Left sided cerebellar lesion
AVR + ICD

St 4
Patient diagnosed as Ca colon, previously missed on colonoscopy due to inadequate preparation

St 5
Diabetic foot
Lymphoproliferative disorder

*****
Lahore 3/22

AR
MG

Chronic diarrhoea

LOBECTOMY
RENAL TRANSPLANT

DELAY IN DIAGNOSIS

PD

RA

****
We were 4 candidates

Started with station 3 and couldn't diagnose CVS and that kind of affected my overall performance I think.

St-3: CVS-low volume pulse and couldn't hear anything apart from the 1st HS so said MS but examiners weren't happy.

(2 of us said MS and other 2 said systolic murmur)

Neuro: Bell's palsy (forgot to mention eye care in Rx)

St-4: MGUS (surrogate was repeating the same question again and again in a Tamil accent so wasn't sure whether she wasn't getting me or i wasn't getting her) In crossing they asked why NT-pro BNP was done which was mentioned in the scenario. I couldn't answer.

((MGUS> amyloidosis> heart failure> nt Pro BNP. thats quite a long jump)))

BCC-1 : vitiligo patient with h/o weight loss and recent worsening of rash. Told D/D leprosy but didn't examine anything for that. Examiner was very unhappy about that.

BCC-2: young man with LBP. Told AS and seronegative DD. Couldn't finish all the examinations. Told I wanted to do Schober's test and the examiner said to do it but I didn't because 2 min was remaining…

Station-1: Abdomen: Young boy e hepatosplenomegaly e jaundice e a horizontal scar mark extending from rt hypochondriac to almost left side. Told hereditary haemolytic anemia e possible open cholecystectomy. Crossing was on thalassemia.
Respi: ILD e clubbing (said IPF)
Crossing was on causes of ILD and investigations

Station-2: 47y man with peripheral sensory neuropathy for 4m. Takes 20units alcohol weekly, H/O unsafe casual contacts, h/o taking metronidazole 6m back and works in a metal company. Told DD HIV, alcohol. Examiner was unhappy for not exploring metal company job further.

Overall left a very unhappy set of examiners behind 😂 Better luck to me next time. And Good luck to everyone.

******
Station 1 bronchiectasis, hepatosplenomegaly

Station 2 back pain in 61 years old male , history of chest cancer received radiotherapy, for last 10 days he is complaining of back pain

St 3 MR with AF , Upper motor neuron in lower limb for Dd

Communication medical error pancytopenia in pt with methotrexate and trimethoprim for UTI.

Sation 5
Psoriatic arthropathy ,
uncontrolled seizure in epilpsy pt

Cases day 1 .. 8.30 batch.. Islamabad

Station 1.. splenomegaly
Pneumonectomy

Station 2.. sheehans syndrome.. clearcut childbirth and postpartum hge history now presented with fatigue and weight gain

Station 3.. MR with pul HTN
Cranial nerves(6th,7th,9th,10th,11th) involved..it was lateral medullary syndrome...

Station 4 ... STEMI is a 28yrs old man... with post PCI counselling... medications and lifestyle.

****
DIET 2 2023 RAWALPINDI

St 1
Chest lat thoracotomy scar with pleural effusions and drain scars

Abdomen . No finding except jaundice

Neuro vague signs in young man
1 side lmn and other side umnl signs with no sensory or cerebellar
So gave ddx of mixed leision

St2
40 years old male with Right sided chest pain ....6 weeks
Off and on
4 to 5 times a day burning in character and relieving with rest
BP 159/90
Fx sudden death of brother at age of 40
Job heavyanual work
Ddx I gav ACS angina
Hocm

St5

Bcc1 haematemesis and malena
1 episode 32 to 4 tea spoons
Fresh blood
Dx said once in month
Patient was citric,palmer erythematosus
So ddx I gav v.bleeding
Nsaid induces

Bcc2
DM1 with dizziness
Inside pt gav hx of Dzzi when standing from sitting. Px had pneumonia 10 days back and then this dizziness started.

Ox surgery . Some kidney tumour which was secreting some hormone
Dx insulin
Patient having pigmentation all over and inside the mouth.
Gav ddx of addison

St 4 : nurse took gliclazide. Concerns will you breach confidentiality?

Diet 2 Cases :

DIET 2 2023 RAWALPINDI

St 1
Chest lat thoracotomy scar with pleural effusions and drain scars.

Abdomen :. No finding except jaundice

Neuro vague signs in young man
1 side LMNL and other side UMNL signs with no sensory or cerebellar. So I gave ddx of mixed lesions.

St2
40 years old male with Right sided chest pain ....6 weeks Off and on. 4 to 5 times a day burning in character and relieving with rest. BP 159/90.
Fx sudden death of brother at age of 40
Job heavy manual work
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Dx insulin
Patient having pigmentation all over and inside the mouth.

Gav ddx of addison

St4 nurse took gliclazide
Concerns will you breach confidentiality?

Hepatomegaly
Pneumonectomy
Mvr

Medical error forgotten dose in a known epileptic patient leading to fits

Hypothyroidism due to iodine ttt
Recurrent fever + travel history

Station 1
-RA with ILD
-Splenomegaly

Station 2
-RA history with SOB for 3 days

Station 3-
- CABG + AVR
- oscillating nystagmus

Station 4
Post EGD dilatation leads to perforation in achalasia pt. Counsel son regarding what has happened and convince not to take patient home

Station 5

Bcc 1 loose stools , hyperthyroidism

Bcc 2 confusion, collapse , cause (cardiac arrhythmia)
Aoa. These are the individual findings. Real findings could be different. It's just a personal experience.

Station 1: Resp: Mild clubbing, B/L basal coarse crepitations changed on coughing D/D Bronchiectasis, B/L pneumonia.

Abdomen: B/L renal mass D/D ADPKD, B/L hydronephrosis , Renal CA . Had time so, also checked for Eye and pronator drift .
Station 2: 29 male K/O Asthma 10 years . Now from 3 months had wheeze , cough and SOB , *Job changed 3 months back . D/D Occupational asthma.
GERD .

Station 3:
CVS: pansystolic murmur radiating to axillaD/D : MR , TR and VSD .

Neuro : LL exam. Pt power was decreased in the left leg distally. Reflexes absent . Sensation reduced in Right leg , Left leg heel shin abnormal .D/D : , Stroke (PICA). CIDP , difficult Case 😏.

Station: 4 , Known case of epilepsy.Well controlled from last 10 years . Taking levetiracetam. Yesterday he was admitted for arthroplasty. He was asked to be an NPO from 6 am in the morning by the pre Assessment team . He missed the dose Levetiracetam . He had a seizure in the evening. Pharmacist told him that he should not miss the dose. Now he is informed by the medical team to inform the DVLA and he needs to stop driving for 1 year .

Concerns: 1. Who is responsible for my missed dose?
2 : I drive daily for my work , I cannot stop driving.
3 : Is there any compensation becoz I would not drive for 1 year.
Station:5 , BCC1, Young male feeling fatigue on exertion .
On Hx he said having left arm pain. ESR raised .(It was a clue but I missed)🤐
D/D Vasculitis - Takayasu arthritis. Aortic valve disease .it was a difficult case . I could not diagnose Takayasu. I said Aortic valve disease 😔.
BCC-2: 55 yrs old male having progressive abdominal distension.
On Hx : Hx of HBV 5 YEARS.
Hx of pulmonary T.B
Pt had abd pain so asked the examiner for examination.He stopped. I Offer for Liver , slpeen , shifting dullness and DRE .
D/D : HBV related DCLD .
 HCC .
Abd T.B
Viva was on DCLD .
 Thank you . ☺
Aoa. These are the individual findings. Real findings could be different. It's just a personal experience.

Station 1: Resp: Mild clubbing, B/L basal coarse crypitations changed on coughing D/D Bronchiectasis, B/L pneumonia.
Abdomen: B/L renal mass D/D APCKD, B/L hydronephrosis , Renal CA . Had time so, also checked for Eye and pronator drift .
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Viva was on DCLD .
 Thank you . ☺
St4
Suicidal assesment
Nurse took gliclizide

Medical error
Missed drug dose causing epileptic seizures

Pharyngeal pouch missed on barium swallow now done endoscopy and got that.

Complication of procedure

Esophageal perforation during ogd

Disease explanation
Chrons and its treatment
Hi !

St 1 pneumonectomy . Polycystic kidney disease

St 2 Pots Syndrome

St 3 spastic paraplegia with lost dorsal column . VSD

St 4 ulcerative colitis management and diagnosis

St 5 wegener's granulomatosis .
Hepatic ence
St4
Suicidal assesment
Nurse took gliclizide

Medical error
Missed drug dose causing epileptic seizures

Pharyngeal pouch missed on barium swallow now done endoscopy and got that.

Complication of procedure

Esophageal perforation during ogd

Disease explanation
Chrons and its treatment

St2

Pots

Palpitation

Poorly controlled asthma ie occupational

RA with sob
On biologics
No TB contact
Acute inf

Wt loss known case DM1

Chest pain IHD,GERD

Poorly controlled asthma recently ie Churg Strauss
St3

Cvs :
Mixed lesion MS,AR

Neuro
Ptosis with fixed dilated 3rd nerve palsy

St4
mom admitted
With uti previously was on parkinson's 3 years ago now came with disability..

Bcc1
65 years male with wife on train station and rush and lost consciousness
On ex Aortic stenosis

Bcc2 young male facial rash 6 month hx early morning joint pain and stiffness with active synovitis
 Treated case of TB list of drugs
And having list of medications
Ddx sle

St1 lat thoracotomy scar with pleural effusion drain scars as wel.

Hepatomegaly with massive spleenomegaly
Stria over abdomen and ascites

St2 26 years old
Dm1 with hypoglycemia episodes
Well educated and learned abt insulin

Ddx
Diabetic autonomic neuropathy
Addison
APS2
Dubai diet 2 today

History:
PMR with Anemia/Raised ESR/muscles aches
Station 4
Suicidal attempt with Paracetamol presented 12 hours after incident

Acetylcystein ongoing but cannula removed by pt and reluctant to continue treatment

BCC1 Hypercalcemia
Was on HCT+ VITD
BCC2 Psoriasis with joints pain & stiffness
Neuro
Weakness proximal more than Distal
Bilateral Pescavis/hammertoes /Hypotonia /reflexes present with Normal sensations

Abdomen
I picked APKD
But I did exposed pt chest and there was cath for dialysis

Respo
I made it COPD with Cor Pulmonale
JVP/Edema

3/22
****
My Exam Cases Diet 3/2022. Rawalpindi Pakistan
Station 1 : Respiratory (18/20)
Diagnosis. Bronchiectasis acute exacerbation.
Findings. Tachypnea. 21/Min ---Tachycardia 110/min----Blue inhaler-----Clubbing---Chest expansion reduced---Bilateral Course Crept change on coughing.

Examiner Questions :Findings---D/D---Management includes investigations and treatment.

Investigations. CBC with CRP/ESR---CXR, HRCT, ABGs, Sputum analysis, PFTs.

Treatment. Acute Management= ICU admission—Oxygen Supplementation---Bronchodilators--- Antibiotics Long Term Management= Pulmonary Rehabilitation including postural drainage and physiotherapy—smoking cessation. Rotatory antibiotics-vaccination --LTOT

Then asked about criteria for LTOT.

Abdomen (20/20):
Diagnosis. Hepatosplenomegaly Pallor—No peripheral signs of CLD, no Lymph nodes palpable. Liver and spleen palpable.

Viva: Findings D/D Investigations Management.

Station 2: (20/20)

Microcytic Anaemia
Scenario outside= 33 yrs. lady, C/O Fatigue, Ankle swelling—HB 9.2 MCV 77—Father died because of colon cancer.

Inside---- fatigue for 8 months, exertional dyspnea. Ankle swelling 3 months. L/M for 10 years.

—no malabsorption features like difficult to flush, floating on pan or any association with any type of food like bread or pasta.

Nocturnal diarrhoea as well.

Upper abdominal pain for 10 years.

no features of IBS (No stressors in life, pain not relieved after passing stools, no alternating constipation.

No melena or bleeding per rectum.
No Hx of fever, change in appetite, Weight changes, Lumps or bumps.

Systemic inquiry was normal. Rheumatologically + renal + No skin rash, no eye symptoms.

Dietary Hx All types of food intake.
Past Hx. H/O Road traffic accident 8 months back, no major injuries, mild pain in hip joint after trauma, was taking NSAIDS.

Medication Hx. PPI for 10 years for stomach pain Irregular periods.

Concerns. Do I have colon Cancer like my father? Are my symptoms because of PPI?

D/D? I said I cannot exactly tell the diagnosis.
NSAIDS induced Upper GI bleed.

Iron Deficiency Anaemia vs Thalassemia. Coeliac disease, Microscopic colitis , colon cancer, worm infestation.

Investigations & Management.

Station 3 :Cardiology (20/20)

Diagnosis. Mitral stenosis.

Pulse regular-low volume—Apex beat tapping in character. Loud S1, MDM, best heard on expiration in left lateral position.

Viva : Findings? D/D? investigations? -management? Causes of MS? Indications for surgery?

Neurology (20/20) :
Diagnosis -GBS (information walking difficulty)

Examination of Lower Limbs: Findings -Lower motor neuron signs power ⅗

-No sensory involvement
-Foley's catheter in situ

Viva: Findings? D/D? Investigations? Management?

STATION 4 :(13/16)
A 35 Years old male brought to ER by ambulance after attacks of fits in his office. Diagnosed as meningococcal meningitis after Investigations. GCS was 7/15. He was intubated and transferred to the ICU. Task was to sit with his wife and address her concerns.

Understanding the condition Wife said he had a mild headache for 2 days and low grade fever yesterday and took Panadol and remained fine , went to his office .Now your hospital staff called me.

I explained the condition and diagnosis and took it as BBN.

I clearly explained that the prognosis is not good and even patients can die. But she didn't look very upset and started asking questions.

Is it communicable?
Is there any risk of disability? Like what? Should I send my son to school?
Can I see my husband?
Should we inform anyone?
Should we take any prophylaxis medicine?

I touch contact tracing, public health, infection control, patient isolation required and prophylaxis during addressing her concerns.

When her concerns were completed then I asked, " Living wish? LPA? AD?

Patient's wife starts weeping and asks if he is going to die, doctor? I explained it as a possibility.

Times up

Thiruvananthapuram

2/24
Day 1,carousel 1
05/06/24:

Thiruvanthapuram

Resp:Bronchiectasis(examiner asked about postition of trachea,may be slightly left)

Abdomen:Splenomegaly (35 years male patient)

Neuro:
B/L foot drop,High stepping gait,Peripheral motor neuropathy (40 years patient)

Cardio:MR

LCC1:Psoriasis with psoriatic arthritis

LCC2:Fever,Headache & photophobia for 2 days

Communication

1.Counsel regarding NAFLD
2.functional disorder

******
Day 1,Carousel 3
05/06/24
Thiruvanthapuram

Very difficult carousel.Candidates were extremely puzzled & unhappy.

Resp:Bronchiectasis(vocal resonance might be increased in some portion?)

Abdomen:
Left palpable kidney
Right lumbar region scar(only anterior approach)

Crossing was...is it transplanted kidney or not.
No candidate could find a mass.

Cardio:None could get this exactly.Faint murmur(systolic/diastolic)...
Pulse volume was good to high volume.

Neuro:Unilateral LMN type 7th & 8th palsy(PROM was vision problem,examiner asked did you read the PROM,none could get any ocular finding)

LCC1:Angioedema(asked all triggers)
LCC2:Infective endocarditis (AVR)

Communication
1.Metastatic breast CA,Dysphagia,
plan:Esophageal stenting & radiotherapy.Counsel daughter.

2.Mrs Atherton is a 52-year-old female with long standing uncontrolled diabetes mellitus and hypertension. Her medical reports suggest she is having moderate proteinuria and retinopathy for quite some time and was started on ACEIs by her GP. She had remained non-compliant with her medications till today.

You're the medical registrar in the diabetes clinic. Your task is to talk to her regarging proteinuria and stress on the importance of taking ACEIs regularly.
****
DIET 2 24
6 JUNE *THIRUVANANTHAPURAM* INDIA

Cardio: TOF with posterolateral thoracotomy scar
Neuro: LMN neuropathy
Abdo: ?Hepatosplenomegaly
Pulmo: ILD
LCC1: Marfan with acute aortic dissection
LCC2: Myasthenia Gravis
Comm1: Daughter of Patient with advanced COPD difficulty in weaning off NIV. The consultant does not want to put ventilator. Granddaughter wedding in 3 months.
Comm2: Newly diagnosed HTN in young smoker male with family history of DM and CAD. Counsel.

******
Day 2
Carousel 1
6.6.24

St4
Pt.70 yrs old.dementia is present. Now admitted with pneumonia.Medical team decide go for Antibiotic.
Talk to son regarding ABX managemt.

Abdomen

ESRD With RRT(Hemodialysis)
Rt.sided nephrectomy scar,lt.sided ballotable kidney.

St5
Chronic diarrhoea

(Celiac,told other dds)

St1

Explain dx+mx of ulcerative colitis

Resp

Bronchiectasis

St2

Heel pain.no h/o trauma

Dds:Gout/septic arthritis

St3
Cardio -AVR

Neuro-Upper limb(MND/CIDP)

******
Station 5 - 25 year old Boy with Abdominal pain and loose stools.

Station 1- Communication - Breaking news of Diagnosis of UC, young air hostess on long haul flights. Planning marriage and family.

Respi - Emphysematous chest, had Bronchiectasis. Left lower lobe was hyperresonant. Trachea shifted to the left.

LCC 2 - 35 year old man with acute swollen left heel

Cardio - MR, Sternotomy scar.

Neuro - Bilateral Wasting of his hands - No sensory signs

Abdomen - Distended abdomen - Scar, paramedian -? Transplant?
Working AV Fistula left arm.

Communication 2- Patient has dementia, son is next of kin. Has been found to have Pneumonia and IV antibiotics have been started. Son wants alternative medication as he is worried about side effects
******
[07/06, 8:03 pm] +880 1713-791511: Day 3,Carousel 1

ST1:

Communication: 70 yrs old lady with jaundice weight loss . Initially usg shows some growth but ct confirms no growth was there. ERCP e stenting done & sample taken which shows no malignancy... treating team still believes this might be cholangiocarcinoma ...talk to daughter.
Respi: COPD/Bronchiectasis

ST2:
Hearing problem+ balance difficulty. NF
ST3:
Cardio: a mitral valvotomy scar present...not sure about the dx
Neuro: PD
ST4:
Ca Caecum with Liver mets .talk to daughter.
You didn't see the pt yet talk to her & address the concerns.
ST5:
SOB with cough.
Pt with Renal transplant e DM e HTN.
D/D:
ILD
Pulmonary Edema
Opportunistic Infection
[07/06, 8:17 pm] +880 1713-791511: Day 3,Carousel 3

LCC 1 - pt with neck pain for 5 yrs(ankylosing spondylitis)
LCC 2-Medication Overuse Headache
Communication 1- pt with DVT previously admitted with gastroenteritis
Comm 2- IBS with amytriptylin
Neuro - wasting, jerk brisk planter not responsive pt also said sensory impairment in one leg don’t know what was that
Cardio- AS with AR
Abdomen - scar no transplant kidney i found but question goes on Renal transplantation
Respi -DPLD/ bronchiectasis

*****★★********
[06/06, 2:41 pm] +880 1670-331698: Day 2
Carousel 1
6.6.24

St4
Pt.70 yrs old.dementia is present. Now admitted with pneumonia.Medical team decide go for Antibiotic.
Talk to son regarding ABX managemt.

Abdomen

ESRD With RRT(Hemodialysis)
Rt.sided nephrectomy scar,lt.sided ballotable kidney.

St5

Chronic diarrhoea
(Celiac,told other dds)

St1

Explain dx+mx of ulcerative colitis

Resp

Bronchiectasis

St2

Heel pain.no h/o trauma

Dds:Gout/septic arthritis

St3
Cardio -AVR

Neuro-Upper limb(MND/CIDP)
[07/06, 8:03 pm] +880 1713-791511: Day 3,Carousel 1

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You didn't see the pt yet talk to her & address the concerns.
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Pt with Renal transplant e DM e HTN.
D/D:
ILD
Pulmonary Edema
Opportunistic Infection
[07/06, 8:17 pm] +880 1713-791511: Day 3,Carousel 3

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LCC 2-Medication Overuse Headache

Communication 1- pt with DVT previously admitted with gastroenteritis
Comm 2- IBS with amytriptylin
Neuro - wasting, jerk brisk planter not responsive pt also said sensory impairment in one leg don't know what was that
Cardio- AS with AR
Abdomen - scar no transplant kidney i found but question goes on Renal transplantation
Respi -DPLD/ bronchiectasis
[08/06, 8:27 pm] +880 1713-791511: 08/06/24:

Day 4,Carousel 3
Thiruvanthapuram

Resp:ILD/Pulmonary edema
(Post kidney transplant+active fistula)

Abdomen:Huge Splenomegaly (Myeloproliferative disorder,Malaria,Kala Azar)

Neuro:Long standing
peripheral motor neuropathy

Cardio:MR

LCC1:Sudden shortness of breath(Pulmonary embolism-patient was taking androgen,trade name deya chilo medication ar)

LCC2:Diarrhoea(Graves Thyrotoxicosis,F/H of colon cancer)

Communication:
1.Pneumothorax(>2 cm air rim,>2/3rd involved,came with sudden shortness of breath)...

regarding counselling & management

2.Mother died due to metastatic lung cancer. But was treated as Pneumonia 4 month ago..

Now meet concerns of son who came to collect death certificate.
****

THIRUVANTHAPURAM
INDIA DIET 2 2024

Salam mam
Exam was good
Inshallah will pass

Station 1
Pt with mnd,talk with son regarding diagnosis and peg tube insertion

Station 1

Copd case
Bilateral wheezes present

Station 2
Systemic sclerosis case

Station 3
CVS-Mr
Cns-poliomyelitis left leg

Station 4
Reaction to penicillin and developed sjs
Explain to husband and need for icu transfer

Station 5
Hemetemrsis
Case-cld
****
DIET 2 2024 INDIA

It was ok.
Cvs-MR
CNS- bl foot drop
Rs- breathlessness with av fistual
Abdo- splenomegaly with jaundice
Commun 1- patients mother has died. He wants to talk regarding death certificate
Comm 2- young patient with recurrent pneumothorax
Lc1- loose stools and weight loss for 1 month with palpitations
Lc2- young patient with 4 hr history of left sided chest pain and breathlessness
****
[12/06, 2:41 pm] +971 55 369 4919: Station 4
Renal transplant
Multiple AV Fistula
[12/06, 2:41 pm] +971 55 369 4919: Station 4
Post partum lady
Stevens Johnson due to penicillin injection
Muti organ failure
Planned for icu and intubation
Inform husband
[12/06, 2:41 pm] +971 55 369 4919: Station 5
Variceal bleed
Diabetic on metformin
Alcoholic
Depressed due to business loss
Hypotension
[12/06, 2:41 pm] +971 55 369 4919: Station 1
Son of father diagnosed with mnd
Planned for PEG

copd / bronchiectasis
[12/06, 2:41 pm] +971 55 369 4919: Station 2
Systemic sclerosis
Presentation Raynauds and SOB with cough
[12/06, 2:41 pm] +971 55 369 4919: Station 3
Mitral stenosis
Post polio

***_______
3/23

****
18/11/23;
Thiruvananthapuram

Lcc 1: Acromegaly (bitemporal hemianopia , frontal headache)

Lcc 2: Methemoglobinemia (both central and peripheral cyanosis; no other symptoms)

Communication 1:
KCO RA patient (diagnosed 6 years back, started on MTX 5 years back), missed appointments with rheumatology clinic many times as she was looking after her mother who has TB ; however managed to visit the clinic few weeks back with worsening of symptoms

Her further rx plan includes Biologics for which CXR was done (which came normal) and IGRA revealed she has latent TB.

She thinks she doesn't need any rx since she is asymptomatic and also knows that her biologics can't be started till her infection has been resolved and she thinks rheumatology clinic is taking revenge on her since she missed few appointments.

Communication 2:
A patient with back pain who had some lesion in T5-T6 area on MRI spine back at that time was treated with antibiotics for 6 weeks with suspected discitis; CT guided biopsy was planned but patient refused

Now patient got readmitted with worsening back pain; another MRI scan revealed progression of old lesion and appearance of new lesion at T8-9 level, medical team thinks it's consistent with metastasis

Spinal multidisciplinary team meeting has reviewed and comes up with a plan to do ct guided biopsy and ct abdomen chest pelvis to locate the primary site of tumour

Patient already knows the latest scan and outcome of his condition. Now Talk to the daughter.

Abdomen:
SVCO with engorged vein in tummy with AV fistula with renal transplant scar

Neuro:
Wasting of hand, some deformity, hypotonia ,hyporeflexia with intact sensation, bilateral pes cavus

Cardio: MS with absent pulse on keft hand

Respi: ILD with cushing

******
THIRUVANANTHAPURAM
DIET 3 2023
 17 NOV

Long CC 1 - young female with raynauds and joint pain For DDx -ss, Mctd, Sle

Long CC 2 - young male with alternating constipation and diarrhoea with abdominal pain - ibs, travellers (travel history +) celiac

Commu 1 - avn caused by steroids for ibs, unhappy patient

Commu 2 - Native valve IE , want to go home , can’t take IV for 6 weeks

CVS - midline Scar +,? AR

Neuro - post polio, MND

Abdomen - Splenomegaly with pallor and mild hepatomegaly

Respiratory - clubbing , lower lobe coarse Crepts left > right…

******
Heard some cases of Thiru from the first 2 days. My exam is tomorrow. Plz pray for me.

N.B. I don't know any details about those cases. Just heard from one candidate.

CNS: Hemiparesis, PN, Motor PN
CVS: As, Mitral commissurotomy, CABG
Abd: HSM, RT, AVF ADPKD? (one sided ballot able kidney) mid laparotomy Scar
Resp: ILD, bronch/COPD

Consultation: Vision loss, chest pain marfan.....Double vision, NF2..... Hemoptysis, Fall with vision problem in DM pt

Communication : PEG, LP, Hemianopia driving, Stroke EOL, pneumothorax, endoscopy delay

******
Thiru today,

Resp- ILD
CVS- CABG scar with normal precordium
Neuro- motor neuropathy with wasting
Abd- HSM

Commu- pneumothorax
Endoscopy delay

Lcc- chest pain- marfan- aortic diss
Intermittent visual loss- MG

****
India Thiravum 16/11/33
🟩🟩🟩🟩India Thiruvananthapuram 16/11/33

Long CC 1 - left sided Chest pain in young patient - ? For DDx - Pneumothorax/ ? Aortic dissection/ ? HOCM

Long CC 2 - Vision impairment, intermittent, Ocular MG
Commu 1 - Pilot , pneumothorax
Commu 2 - OGDS postponed
CVS - midline Scar +, no click, CABG scar + , ESM, ? Bioprosthetics AVR
Neuro - CMT
Abdomen - Splenomegaly
Respiratory- lower zone Pulmonary fibrosis ? Basal Crepts
🟩🟩🟩🟩

2/23

THIRUVANNANTHAPURAM CASES

MRCP Paces

Station 1 :
Abdomen: Middle age gentleman with Hepatosplenomegaly
Respiratory:
Acute ex of COPD, D/D Brochiactesis

Station 2 History: 26 y Women with Palpitation, Coffee shopkeeper, H/O Anxietic disorder taking Sertraline, H/O father died @42 y due to cardiac cause .
D/D: Coffee induced, Anxiety, Familial Heart disease

Station 3:
Cardiology: AS with Heart failure
Neurology: Hemiperesis

Station 4:
28y women air hostage with new diagnosis of UC...councelling...Hidden concerns: BBN, Job, Family planning and false certificate

Station 5 :
1. 55y male with Abnormal sensation in rt hand
Dx: PD
2. 36 y male with polyurea.
O/E: B/L ballotable kidney and painful. No fAmily history. H/O constipation and polyurea.
D/D:
Hypercalcaemia
Due to
1.Tertiary Hypercalcaemia with ADPKD,
2. Other cause of hypercalcaemia

DIET 2 2023
Thiruvannanthapuram cases..

Station 1, Left nephrectomy with Right ADPKD with functioning AVF. COPD with superadded chest infection

Station 2, Post covid with dizziness and palpitation, underlying controlled bronchial asthma

Station 3 , PSM radiate to axilla with midline sternotomy scar with no click, LMNL with no sensory involvement.

Station 4, Type 1 DM with all complications and recent hypoglycemic attacks, talk to reduce tight glycemic control.

St 5 (1) difficulty in using hands with infertility.. Myotonic dystrophy,
(2) Young lady with left sided headache with increase BP...Tension Headache/Migraine
These are today

SYNAPSE
Medical Academy

THIRUVANNANTHAPURAM CASES

MRCP Paces

DIET 2 2023
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These are today

Diet 2 Thiruvananthapuram

BCC1- Heditary Angioedema
BCC2- Neurofibromatosis
Abdo - ADPKD on HD
Respi- Bronchietasis
CVS- VSD
CNS- Surgical 3 rd N palsy
Com- IBS and Amitriptylline
History-RA pt worsening of SOB currently on Methotrexate and Anti- TNF

Station-2 Dizziness & palpitation 2 weeks , just differential
Station 4 - hypoglycemia unawareness issue

SYNAPSE
Medical Academy

THIRUVANNANTHAPURAM CASES

MRCP Paces

Diet 2, kerala india

Station 1
Bronchiectasis/ild
Clubbing/chest crepitation
Abdomen
Jaundice with hepatomegaly/evident
splenomegaly

Bcc
Young lady with left side weakness ..
Head ache /tuberous sclerosis
Cvs
Aortic valve replacement with CABG
Communication
Mitral valve replacement pt had IE need to start antibiotics not willing to stay in hospital...talk and concern
Cns case still i am not sure i did not get time to complete

History /post partum thyroiditis

Resp : Bronchiectasis
Abd: ADPKD with nephrectomy scar
cardio: MVR
Neuro: Motor Neuropathy
St-2 : Post covid syndrome
st-4 : Hypoglycemic awareness
st-5 :
1. Myotonic dystrophy
2. TTH (dummy)

Resp : COPD + Bronchiectasis Probably
Abd: Jaundice, Liver
Heart : MR MVP

Neuro: CMTD/ CIDP
St 2: Chest pain
St 4: PC suicide (not psychiatric, impulsive)
St 5:
1. PsA
2. IBS (Not sure)

SYNAPSE Medical Academy

Respi:COPD with Bronchiectasis
Abdomen : Hepatosplenomegaly with ascites
Cardio:AS
Neuro:Stroke
St 2: a 30yrs female waitress palpitan
H/O SCD father at 42yrs
Sertraline-2yrs

Coffee excess
D/D-HOCM
sertraline induced
Caffeine induced
St4:UC Dx tell and Mx explanation

St5:Idiopathic Parkinson's Disease
Hypercalcemia-
D/D-hyperPTH
sarcoidosis
Nehrogenic DI

Diet 2, kerala india

Station 1
Resp:
Bronchiectasis/ ILD
Clubbing/chest crepitation

Abdomen
Jaundice with hepatomegaly/evident
splenomegaly

BCC
Young lady with left side weakness ..

Headache /tuberous sclerosis

CVS
Aortic valve replacement with CABG

Cns case still i am not sure i did not get time to complete

Communication
Mitral valve replacement pt had IE need to start antibiotics not willing to stay in hospital. talk and meet his concern.

History postpartum thyroiditis

****_******
Resp : COPD + Bronchiectasis

Abd: Jaundice, Liver

Heart : MR

Neuro: CMTD/ CIDP

St 2: Chest pain (HOCM/Vaso Spastic)

St 4: suicidal attempt (not psychiatric, impulsive)

St 5:
1. Psoriatic arthropathy
2. IBS (dummy)

****
Resp : Bronchiectasis
Abd: ADPKD with nephrectomy scar

cardio: MVR
Neuro: Motor Neuropathy

St-2 : Post covid syndrome

st-4 : Hypoglycemic awareness

st-5 :
1. Myotonic dystrophy
2. TTH (dummy)

****
DIET 2 2023

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(2) Young lady with left sided headache with increase BP...Tension Headache/ Migraine

These are today's Thiruvannanthapuram cases. Best of luck for all candidates.

****
Respi:COPD with Bronchiectasis
Cardio:AS

Neuro:Stroke
Abd: HSM with LN

St 2 :Palpitation
St 4: UC Dx n Mx

St 5:
BCC 1:Parkinson's disease
BCC 2:Hypercalcemia

Diet 2 Thiruvananthapuram

BCC1- Hereditary Angioedema
BCC2- Neurofibromatosis

Abdo - ADPKD on HD
Respiratory - Bronchiectasis

CVS- VSD
CNS- Surgical 3 rd N palsy

Com- IBS and Amitriptyline

History- RA pt worsening of SOB. Currently on Methotrexate and Anti- TNF

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Thiruvannanthapuram cases..

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Left nephrectomy with Right ADPKD with functioning AVF.

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St 5 :
(1) difficulty in using hands with infertility.. Myotonic dystrophy,

(2) Young lady with left sided headache with increase BP...Tension Headache/ Migraine

****-*--***
These are today

Abdomen: fistula no scar burns spider navi
I said pt has CKD and on dialysis

Resp: productive cough: copd /bronchiectasis

Hx: eosinophilia with AKI over one month in a 50yr old who takes omeprazole

Cardio: metallic valve replacement- God knows which one as I said dual valve. No one knew.

Neuro : upperlimb ,left cerebellar stroke - examiner prompted me.as I was heading elsewhere.

Comm: epileptic lady, seizure free for 8 years. Had arthroscopy and did not take the meds in morning as was advised by docs.and later the pharmacist said she should have taken she had seizure now and cant drive. Was unhappy. Angry and wanted to complain and asked the doc to ask DVLA to let her drive.

Bcc1: swallowing difficulty in a lady with raynaud's- SS

BCC2: A 30 yr old female collapsed - cardiogenic on hx , could be associated with aspirin.

******
St1
Hepatosplenomegaly
COPD with bronchiectasis

St2
30 yrs lady palpitation
Dd: HOCM, Sertraline induced LQTS, Tea/ coffee

St3
AS with heart failure
Stroke

St4
U. colitis BBN and Mx consultation

St5:
Idiopathic parkinson disease

Renal stone due to hypercalcemia

*****_*_**__

Diet 2 Thiruvananthapuram

BCC1- Hereditary Angioedema
BCC2- Neurofibromatosis

Abdo - ADPKD on HD
Respiratory - Bronchiectasis

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History- RA pt worsening of SOB currently on Methotrexate and Anti- TNF.

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2/23
St1
Hepatosplenomegaly with Ascites
COPD with bronchiectasis

St2
30 yrs lady palpitation
Dd: HOCM, Sertraline induced LQTS, Tea/coffe

St3
AS with heart failure
Stroke

St4
U.colitis BBN and Mx consultation

St5
Idiopathic parkinson disease

Nephrogenic DI due to hypercalcemia, Pyelonephritis, Renal obstruction, Sarcoid

2/24

[25/05, 6:21 pm] +92 324 0580669: *Dubai center 25.5.24 diet 2*

Abdomen.
Splenomegaly with mild jaundice. DD HA vs infection.

Chest COPD
CVS AVR
CNS.. LL

LC -1. DM with necrobiasis
LC-2 RA with numbness of both hands

Communication-1.
Post mi PCI done 2 months back on aspirin panic came with anemia. Mildly anemic on discharge hemoglobin 11 now 7.7.
Angry why missed

Comm 2 ...
Copd with very sick. Unconscious. Son agreed DNR.
Now better fully conscious. To tell her about dnr decision to continue or not. Refusing ABG also. To explain her the importance of ABG
[26/05, 8:59 pm] +92 324 0580669: *Dubai 26.5.24* *diet2*

LCC1 systemic scelrosis
LCc2 .thyroid swlling
Neck pain for 2 week

Comm 1
 medical error
Comm 2
 explain cord compression in patient with small lung cancer

Abd...Heptospelenomeglly with jaundice and pallor
Neuro Proximal myopathy
Cvs .AVR
Chest bronchiectasis
[27/05, 10:44 am] +92 324 0580669: *UAE Evening 26.5.24 diet 2*

LCC-1 - Thyrotoxic Periodic Paralysis.

LCC-2- Guy admitted for sinus surgery, pre op results show Creatinine of 2.5... DDs churg strauss, wegeners, good pasture

CVS: TOF. Post corrective surgery
CNS: LL exam: Polio
Resp: COPD Vs Asthma
Abdomen: APKD

Comm 1
Talk to daughter. Father had COPD, admitted withCURB-5 CAP. Died after 48 hours. Missed 1 dose of Abx because cannula was dislodged and staff couldn't fix because was busy arranging same patient to HDU.

Comm 2
45 Yo found to have metastatic esophageal Ca
Team decided palliative treatment
Patient knew that it was Ca esophagus but Did not know that it has metastasized
Was expecting to get it cured.

*****
[25/05, 6:21 pm] +92 324 0580669: *Dubai center 25.5.24 diet 2*

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Splenomegaly with mild jaundice. DD HA vs infection.

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CVS AVR
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Team decided palliative treatment
Patient knew that it was Ca esophagus but Did not know that it has metastasized
Was expecting to get it cured.
**-

[29/05, 6:17 pm] +971 55 369 4919: Today 25/5 Saturday. At Dubai center 2nd cycle.

Abdomen. Splenomegaly with mild jaundice. DD HA vs infection.

Chest COPD
CVS AVR
CNS LL

LC -1. DM with necrobiasis
LC-2 RA with numbness of both hands

Communication-1. Post mi PCI done 2 months back on aspirin panic came with anemia. Mildly anemic on discharge hemoglobin 11 now 7.7.
Angry why missed

Copd with very sick. Unconscious. Son agreed DNR.
Now better fully conscious. To tell her about dnr decision to continue or not. Refusing ABG also. To explain her the importance of ABG
[29/05, 6:17 pm] +971 55 369 4919: Dubai 26
1st cycle
Long 1   systemic scelrosis
Long 2 thyroid swlling
Neck pain for 2 week

Short
Heptospelenomeglly with jaundice and pallor

Promal myopathy

AVR

bronchiectasis

Communication
1 medical error
2 explain cord compression in patient with small lung cancer
[29/05, 6:17 pm] +971 55 369 4919: 27th MAY:

LCC
ST5 acute pancreatitis.
2ndry Hemochromatosis to thalassemia
Abd:splenomegaly
Chest OLD
Cardio MVR&AVR
Neuro: PSMN

Comm.station:
Case of MND&Aspiration pneumonia, discuss diagnosis &management&PEG tube insertion.

Comm2
2patches in CXR since 6weeks and repeated CXR showed same patches. Px has a history of lumpectomy &chemoradiotherapy 2years ago for breast cancer.

Not happy she wasn't informed about the opacities in earlier admission

1/24

****

DUBAI DIET 1 2024

Lcc : 1.middle aged woman with excessive hair growth , androgen level normal
2. Middle age man with hand pain for 1 yr. Dupuytren contracture

Communication: 1. Pt of diabetes with complication , refusing for insulin injection
2.Pleural effusion malignant , discuss management of Pleural effusion

Cvs : avr
Cns : spastic lower
Resp : Bronchiectasis
Abdomen: Renal transplant

*****

AJMAN DIET 1 28/02/2024

SHORT CASES:

Cardio : MR
CNS: LL Mixed UMNL&LMNL (frederick ataxia)
Abd: Hepatomegally + scar (splenectomy) —> thalassemia
Chest : no idea !!

Communication scenario 1:
Stroke given thrombolytic ttt after discussion with him and his wife, develop hemorrhage , GCS 7 .. DNR in his file before also discussed before and wife knew about it ,, BUT inside wife will said no one tell us about SE of thrombolysis can cause hge , & she signed papers in hurry without readings the SE of it …

Communication 2:
Salesman & driver ,, uncontrolled DM with complications (microvascular) need to start insulin and he refused .. try to convince him ..(written outside “as per local regulations driver is not prohibited if pt on insulin”) ..

LCC1:
Palpitation with dizziness >> on examination it was Mitral Regurgitation

LCC2:
Pt with high LFT , TG, cholesterol ,, >> most probably NAFLD ,, and other DD of hepatitis (colleague said there was hepatomegaly🤦‍♂️)

*****

ajman/ uae 2nd cycle 22/11
Comm:

one pt with infective endocarditis explain and pt want to go home
Duration of rx is 2weeks 2types of antibiotics iv he want to go home cuz of wark issue and his family r alone he has kids no one is staying with them and duration of
staying in hospital is long

Other communication :
Cancelled endoscopy in pt with malena due to pt not able to fully prepaired still passing back passage explain to him and advice him about alternative procedure they ask like ct
Her concern why cancelled and she is worried about to have cancer
Consultation:parathesia in hands when i ask him which parts he point the ulner region of the fingers PH of DM on diet control he work in library
Other consultation:femal lady 45yrs as i remember c/o chest pain which is all over dull no relation with respiration or posture pH of PCI 2months before known DM bad control Hypercholestrolemia with xanthelasma

Ajman center
Started with st 3
Cardio st examine this pt with SOB
It was pt with mid sternotomy scar
AVR
Pt not pale no sign of overload and even not have SOB
Examiner Q was finding
Diagnosis
How can u manage the SOB
Neuro st
Unilateral flacid paraparesis
Poliomyelitis
EQ was Dd
Finding of MRI in Poliomyelitis
St 5 1: skin rash
Inside vetiligo with tiredness
Discussion was about pernicious anemia
2: vomiting blood
Inside
Pt with lion pain went tonER recieved painkiller inj then developed the vomiting
St 1
Abdomen APCK
Copd

DIET 3 2023 DUBAI ✍️

PCKD in abdome
COPD in respo
Proximimal myopathy in CNS

AS and MR with AF in cardio (I missed AS and cost me marks in dd and in physical signs)

Long clinical
1 thyroid
2 psoriasis

Communication repeat cases of :
1. palliative and end of life care
2. MND with recurrent aspiration for nutritional options

No surprises in exam ALHAMDULILLAH

3/23
Sharjah cases
Day 1
LCC 1:
Scenario: 32 years old female, having abdominal pain, anorexia and diarrhoea, vitals normal.

Inside: young female with travel history, had diarrhoea with bleeding PR, took antibiotics, now she has foul smelling watery diarrhoea for 3 weeks.

Discussion about travellers' diarrhoea, Cl. Diff infection, IBD.

LCC 2:
Scenario: 47 year old male with limb stiffness and slowness, vitals normal.

Inside: tremors, stiffness and slowness.

Discussion about parkinson, parkinson plus, wilson etc

Comm:
BBN: patient brought with STEMI, he was taken to the cath lab, there was a complex block, he had cardiac arrest on the table and died.

Task : Inform the wife.

Cardiologist who did PCI is busy in another emergency CAG.

Comm 2:
A 45 years old female, known COPD, with previous exacerbations, came again with exacerbation, now in MAU, she had recovered well after previous admissions. Currently she was unable to perform her routine work, requiring help at home.
She also has multiple myeloma which has not responded to 5 different chemo regimens.
She has already agreed on DNAR.

Discuss with her admission to ITU/ HDU.

Cardio: AS
Neuro: Sensory motor polyneuropathy
Abdomen: Pallor, Jaundice,
hepatosplenomegaly

Resp: pulmonary fibrosis + scleroderma

Diet 2/23

St 5
BCC1: Outside : Abdominal pain

1 day. Nausea, vomiting, collapse.
Also before.
Skin darker, palmar crease also.

Forget to examine the abdomen..

Asked why not abdomen - to find other signs of Addison disease .

What do you want to add? - to find other signs for APS.

BCC 2 : Cramp, tingling and numbness.

Around the mouth.

P/H - Thyroidectomy.

Has a thyroidectomy scar.

Dx - hypocalcemia.

Asked what is common? Don't know.

Then asked - have you asked for dietary history?

Why have you asked about illicit drugs? - I don’t know but asked as a routine.

St 1
Abdomen :.Ascites + deep jaundice.

Common cause of liver disease?
Treatment of ascites?

Resp: patient having wheeze.

Dx?
What do you for him?
Do you want to admit him?

St 2
Knee pain

PH - UC for 4 years taking azathioprine

Other drugs - aspirin & thiazide diuretics.

Investigation?
For repeated episodes will you give allopurinol?
Why don't you want to give NSAIDS?

St 3
CNS :
Thin limb, pes cavus.
Spastic bilateral, exaggerated jerk.
Sensory - dorsal column.

What is the most common cause?
Treatment option? For spasticity?

CVS:
Pulse - can't feel.
Can hear from bed end?

Said DVR - are you sure?
Is valve working?

St 4

Complication of procedure.
Has dizziness.

The Pacemaker was inserted & dislodged.
Need to pace again.

I don't want to go again? I am going to marry.

They have pushed me to do this. Why?

I don’t want to have it by the same doctor again?

Can you guarantee it won't happen again? .

Diet 1 2023 Dubai

Station 1 bronchiectasis, hepatosplenomegaly

Station 2 back pain in 61 years old male , history of chest cancer received radiotherapy, for last 10 days he is complaining of back pain
St 3 MR with AF , Upper motor neuron in lower limb for Dd

Communication medical error pancytopenia in pt with methotrexate and trimethoprim for UTI.

Sation Psoriatic arthropathy , uncontrolled seizure in epilpsy pt
*******--
St 5
SS with dysphagia CREST
DM dermopathy

St 1
Splenomegaly
Bronchiectasis

St 2
Recurrent fall

St 3
MVR
Sensory motor neuropathy, charcot joint

St 4
Mesothelioma

Dubai experience
St 1
COPD
Renal transplant (questions about if tenderness and pain: diagnosis? investigation? Urgent management?)

St 2
Female 47 years, Fatigability, Low MCV anaemia , normal TFT. menorrhagia since the beginning. malabsorption diarrhoea for 3 years (diagnosed as IBS but not investigated at all), hx of travel to caribbean 6 months ago (the surrogate is very talkative)

St 3
Proximal myopathy
COPD

St 4
Medical error. Pt admitted for MRI and LP . MRI done, wrongly administered Rivaroxaban and bisoprolol of another patient who shares the surname
An incident report was raised by the pharmacist. Task to explain the situation and the action to the patient.

St 5
Anterior neck swelling , euthyroid
Hand pain in rheumatoid arthritis , no signs of activity

Dubai diet3
St2 hemiplegic migraine

St4 bilateral opacities missed on chest x-ray . Medical error

St5 syst sclerosis and hypothyroid lady on ferrous sulphate

Neuro bilateral foot drop
Cvs avr
Abdomen adpkd on dialysis catheter
Chest copd e mer benz scar

_____**
Dubai day 1 (3rd run)
station 1
abdomen..huge splenomegaly
discussion on myelofibrosis

chest ..instructions ; recurrent chest infectionpt has clubbing in both upper and lower limbs..chest finding not clear
discussion on cystic fibrosis

station 2
fever.sweating. wt. loss , lumps and bumps. discussion on lymphoma

station 3
CVS .. clicky heart sound with irregular pulse ? not sure if aortic or mitral

CNS.. ?? proximal weakness, has scar in his thigh
discussion on myopathy

station 4
scenario covid with anxiety ..

pt. is post kidney transplant for 10 yrs
admitted with mild covid infection
he is candidate for escalation of management if deteriorated
c/o SOB seen by consultant
he is vitally stable spo2 96 % on RA
pt. is anxious .. talk to him
concerns..

*I am worried as i witnessed deaths in the ward because of covid
*am i going to die ?
* can i live a normal life .. when does this covid will end
*my antibodies for covid are low despite vaccination .. examiner commented that i should reassure that Ab level normally drop after vaccination

station 5
BCC1 lady with hirsutism ..increased hair in legs arms and back despite laser .. +ve FHx of hirsutism ..her mother ..her sister has PCOS..no wt. change .. cycles are regular

BCC2
RA + carpal tunnel syndrome

Diet 3 2022 dubai

Station 1
Resp COPD and bronchial breath
Abd jaundice and ascites CLD

Neuro: LMN type of weakness with intact sensation DD
AIDP/ SMA/ Myopathy

CVS MR

Station 2 young male seronegative arthropathy coming with left knee and right ankle pain
Reactive arthritis was main dx

[08/03, 11:23 pm] +880 1536-213895: Dubai

Station 1 bronchiectasis, hepatosplenomegaly
Station 2 back pain in 61 years old male , history of chest cancer received radiotherapy, for last 10 days he is complaining of back pain
St 3 MR with AF , Upper motor neuron in lower limb for Dd
Communication medical error pancytopenia in pt with methotrexate and trimethoprim for UTI.
Sation Psoratic arthropathy , uncontrolled seizure in epilpsy pt

[08/03, 11:23 pm] +880 1536-213895: Dubai exam today
Station 3 neuro peripheral neuropathy and Charcot joint

CVS: MVR
Abdomen : bilateral kidney enlargement + portacath
History: itching
The cause is lymphoma
Communication: patient want to discharge against medical advice did CT and refuced LP
Bcc1 non toxic goiter
Bcc2 chronic cough for DD

Ajman

Communication was young female with missed ovarian cyst on MR and we had to tell her that it was missed 3 months back
And we had to tell her referral for scan

BCC1 migraine in young female on OCP

Bcc2 hyperthyroidism with graves ophthalmopathy

Station 2 young male with itching, lymphoma

Station 3 cvs MR
Cns Parkinsons but command was to examine lower limbs

Station 4 post mi and post pci after 2 months counselling for meds

Station 5
BCC 1 Sudden onset of right side vision loss likely stroke
BCC 2 young male with vitiligo , tried finding associated auto immune but he had no other symptom

Station 1
Chest copd
Abd thalasemia with splenectomy

[16/03, 6:57 pm] +880 1536-213895:

Station 2 young male with itching, lymphoma

Station 3 cvs MR
Cns Parkinsons but command was to examine lower limbs

Station 4 post mi and post pci after 2 months counselling for meds

Station 5
BCC 1 Sudden onset of right side vision loss likely stroke
BCC 2 young male with vitiligo , tried finding associated auto immune but he had no other symptom

Station 1
Chest copd
Abd thalasemia with splenectomy

[16/03, 6:57 pm] +880 1536-213895: Ajman center today cycle 3

Cvs: aortic valve replacement
Cns: parkinson dx(surrogate not real patient)
Abdomen: CLD(shrunken liver+spleenomegaly)
Cest: COPD (PT had scar parrel to spinal cord in back lumbar area!!!! I couldn't figure out the cause at that moment.
History:
Pt with H/O renal transplant before 20 yrs rejected 10 yrs after and transplanted again then develop lymphproliferative blood cancer received ttt and resolve completely today came with abdominal pain nausea vomiting diarrhea 2 times per day his medication
MMF + predinslone10mg+ tacrolimus+ ACE-i +omeprazole
His main concern about cause of abdominal pain? I forget to offer him analgesia and examainer uppset about that

Communication
Pt 45 yrs male work in shipyards for 20 yrs and still working came with chest pain ,imaging show evidence of mesthiloma decide to take a biopsy with guide
Pt father and brother have same diagnosis and pass away in miserable shape, pt live alone divorce with 2 kids, concerns mainly about is it heart attack???

St5
-Neck swelling multinodular goiter
-Headache after her father pass away 3 weeks back ,no postive other history no postive examinations

United Kingdom

2/24:

Neuro. Lower limb exam. Chorea athetosis in upper limbs

It was chorea/ tardive dyskinesia secondary to anti parkinson meds.

Chest pneumonectomy

Cvs.Metallic avr. very obese pt.
Second heart sound was loud audible through chest
I mention both metallic tissue valve examiner said mention one so i met with metallic heart avr

Long case 1 - collapse during driving.
Osa was the cause.

Lcc2 Recurrent chest infection, no weight loss, hx of asthma.

Comm1
Comuncnt mother died 2 days ago son here for death certificate. address his concerns.

Com2
Was functional disorder diagnosis with pt

James Cook Hospital
UK 14/08/2024

Lcc 1: shortness of breath .. PE
Lcc 2: lethargy and diplopia
Myasthenia Gravis

Comm 1: medical Error
Comm 2: NASH with cirrhosis

Resp: Bronchiectasis
Abd: renal transplant
Neuro: polio
Cardio: CABG with device
Tissue AVR

11.8.24 diet 2 UK

Neuro peripheral neuropathy
CVS AVR

RESPI. ILD
Abdo. CLD

LCC1 Adrenal crisis
LCC2 leptospirosis

Communication
Medical error
Palliative care

UK Today cases
29/07/24
Liverpool

Comm 1: explain The patient about neurologically unexplained symptoms functional disorder

Comm 2: Uncertainty of diagnosis of cholangiocarcinoma after ERCP and biopsy counsel for repeat biopsy and further testing.

Lcc1: backache.. psoriatic arthropathy
Lcc2: young patient with palpitations htn and weight loss... normal examination..likely thyrotoxicosis, pheochromocytoma

Cardio: MR with a thrill in mitral area with rheumatoid hands

Neuro: peripheral neuropathy

Abdo: massive spleenomegaly

Resp : PEFR beside the patient normal examination discussion about CF

London Yesterday Cases
28/07/2024
Diet 2/2024
Morning cases

Cvs: MVR
Abd: liver transplant
Neuro:CMTD
Resp: pneumonectomy

Lcc 1: Parkinson
LCC 2: peripheral neuropathy

Comm 1 : Gliclazide toxicity
Comm 2 : Medical Error

London Today's cases
28/07/2024
Diet 2/2024

CVS- MR

Neurology- Facial palsy due to CP angle tumour

Abdomen- hepatomegaly

Chest ILD

One clinical consultation was POTS

2nd clinical consultation was cardiac arrhythmia/Postural dizziness

Communication was- Medical error , nurses missed IV Abx because the patient was pulling out the cannula

2nd communication was abnormal LFTs - non-alcoholic hepatitis... so the consultation was to avoid a sedentary lifestyle and junk food.

diet 2 8.7. 24
Centre UK Glasgow

Station 1 communication
Counsel a lady about chronic renal failure and possible dialysis in the future

2nd consultation was regarding a man complaining of double vision worse at the end of day it was myasthenia Gravis

Communication was breaking bad news of motor neuron disease to son and take consent for peg tube insertion

Another LCC was a young lady complaining of a 2 day history of loin pain and fever past history of uti in pregnancy as well. It was I guess acute pyelonephritis and resistant/ recurrent uti.

Abdomen exam was liver transplant

CNS exam was peripheral sensory motor neuropathy

Respiratory was bronchiectasis

CVS I couldn’t pick up

******
DIET 2 2024 UK

29 JUNE

station 1 communication warfarin for pulmonary embolism need to be started. risk and benefits

resp lobectomy
consultation neurofibromatosis pt came with epilepsy 60/M htn dm on metformin
cvs MR
neuro Peripheral neuropathy HSMN

station 4 ibs diagnosed started on amitryptaline answers concerns

consultation pneumonectomy pt came with sob distended neck veins svc and ivc obstruction

****
Station 1 communication
Counsel a lady about chronic renal failure and possible dialysis in the future

Communication was breaking bad news of motor neuron disease to son and take consent for peg tube insertion

Station 4:IIBS. diagnosed, started on amitriptyline answers concerns.

Station 1 :communication warfarin for pulmonary embolism needs to be started. risk and benefits

******
UK DIET 2 7.7.24 *PORTSMOUTH*

Lcc 1 HTN with confusion and visual abnormalities
PRESS/Htnsive encephalopathy

Lcc2.... chronic diarrhea

Chest pneumonectomy

Cvs .....AS with pacemaker

Abd.... Liver transplant

Neuro....INO with homonymous hemianopia, MS

******
[25/06, 10:58 pm] +92 324 0580669: *16 .6.24 *UK diet 2*

Comm 1
Esophageal Ca diagnosed on endoscopy mets on ct cap do BBN offer palliative care

Comm 2
PD / dementia/chest infection /confusion / discus feeding options with daughter.

Abd .. cld with hepatomegaly with PD catheter

Chest pleural effusion/ clubbing
CVS AS
CNS... lmn type arm monoparesis
With sensory loss

Lcc 1 difficulty im walking
Inside Peripheral sensorimotor neuropathy

LCC2 neck swelling with lymphadenopathy
[01/07, 12:19 pm] +92 324 0580669: *UK 29.6.24*

Lcc 1
Swallowing problem with longstanding heart burn bp 160/90 .. inside SS

LCC2
P/C 3 weeks history of Nausea vomiting diarhea bp low potasium low .. inside addison's
K/c Type DM1

Comm 1
Mnd pt had swallowing problem new diagnosis MND. explain to pt son
Discus possibility of gastrostomy tube

Comm2
40 yr old lady referred to opd for loss of appetite ,lethargy blood tests and usg show ckd
Explain new diagnosis

Cvs metallic valve replacement
Chest ild

Neuro peripheral neuropathy
Abd renal transplant
[01/07, 12:20 pm] +92 324 0580669: *UK 29.6.24 London Centre*

Communication 1:
Patient with COPD needs to start NIV and patient refusing

Communication 2:
Patient had STEMI and stented previously. Came in with anemia and need to stop DAP and discuss further management for colonoscopy

LCC 1
Young lady came in with collapse, found to be sezuire. Has headache
Has abdo pain and diarrhoea for 5 weeks. Had chest infection same around that time.

LCC2:
SOB+Cough

Cardio:Systolic murmur all over the precordium AS

Neuro: facial palsy
Abdomen: kidney transplant
Chest: consolidation
[01/07, 12:20 pm] +92 324 0580669: *UK 30.6.24 Manchester Centre*

Communication 1:
Meningococcal meningitis with sepsis requiring Icu

Communication 2:
Metastatic esophageal cancer for Palliative care

LCC 1
Headache and bodyaches.....GCA

LCC2:
Syncope

Cardio:Systolic murmur all over the precordium AS

Neuro: CMTD

Abdomen: Massive spleenomegaly

Chest: Ild+clubbing
[05/07, 12:36 pm] +92 324 0580669: *UK diet 2 4.7.24*

station 1 communication: father with LBD admitted with pneumonia. SALT assessed not safe swallow. NG tube inserted with mitten. daughter found him urinating on bed. to update daughter

resp: blue inhaler, gynaecomastia ? COPD

station 2 61 retired nurse with known pernicious anaemia had lethargy, general body weakness and weight loss. fh sister thyrotoxicosis, PMH osa on cpap overnight. patient concerns ? malignancy

station 3 neurology - dystrophic right leg, flaccid tone, reduced reflex and power 2/5. ? polio

cardiology - median sternotomy scar, loud s2 at the aortic area, ? aortic valve replacement, ? cardiac transplant.

station 4 communication: 33F recent admission with ? gastroenteritis had vte assessment done but not prescribed. came back with leg pain confirmed dvt. wants to get pregnant but has to delay her plan due to the dvt.

station 5 40yo male known CF had 5x chest infection, had amoxicillin and clarithromycin but no improvement. deranged LFT. sputum culture pseudomonas. lost to follow up with CF clinic. want to get a child. lost stool with difficult to flush stool.

[05/07, 12:37 pm] +92 324 0580669: *UK diet 2 4.7.2024 Liver pool*

Comm1 : UC with high grade dysplasia and proctocolectomy

Abd : midline laparotomy scar with splenomegaly

Lcc 1 ; psoriatic arthritis

Comm 2 : meningococcal septicemia

Resp: anterior chest scar with normal chest examination

Lcc 2: headache... GCA

Cardio: systolic murmur in aortic area

Neuro: unilateral arm wasting with absent all sensation
[06/07, 12:36 pm] +92 324 0580669: *UK diet 2 4.7.24*
reading hospital

Lcc 1
Back pain seronegative spondyloarthropathy

Lcc2

Raynauds systemic sclerosis

Cvs Metallic aortic valve with PPM
Neuro Sensorimotor neuropathy
Chest Lung cancer with pleural effusion

Abdomen midline scar mass in RIF and mass in Left flank .
Pt had vitiligo old AV fistula

Comm 1
mengiococcal meningitis and ITU admission

Comm2
Breaking bad news of colon cancer..

[07/07, 12:18 am] +92 324 0580669: *U.K diet 2 6.7.24 southampton*

Lcc1 Tia
 lcc2 - peripheral neuropathy secondary to diabetes , alcohol

Abd- renal transplant
Neuro was Ms
Chest was pneumonectomy
Cvs - metallic aortic valve

Comm 1 Error- given
Comm 2 Breaking bad news - lung shadows on cxr

[07/07, 12:19 am] +92 324 0580669: *UK DIET 2 6.7.24* *PORTSMOUTH*

Lcc 1 TIA/GCA??? Loss of vision transient
Lcc2 Systemic sclerosis
Abd Liver transplant
Neuro Spastic paraparesis
Chest ild
Cvs AS

Comm 1 Error- given
Comm 2 Breaking bad news - lung shadows on cxr

[07/07, 12:20 am] +92 324 0580669: *UK Today 6.7.2024*

Resp: lat thoractomoy scar with RA hands

Comm 1: asthmatic lady with previous Hx of breast cancer with 2 lung shadows discharged with being informed about shadows again xray after 6 weeks show same shadows

Lcc 1: collapse.... cardiogenic/ medication induced.

Cardio: AVR

Neuro: CMTD

Comm 1: asthmatic lady with previous Hx of breast cancer with 2 lung shadows discharged with being informed about shadows again xray after 6 weeks show same shadows

Comm 2: Drug allergy medical error

LCC 2: collapse with positive family hx of sudden cardiac death .... arrhythmia / HOCM

Comm1 : UC with high grade dysplasia and proctocolectomy

Comm2
Breaking bad news of colon cancer..

Comm 2 Breaking bad news - lung shadows on cxr

[01/07, 12:19 pm] +92 324 0580669: *UK 29.6.24*

Lcc 1
Swallowing problem with longstanding heart burn bp 160/90 .. inside SS

LCC2
P/C 3 weeks history of Nausea vomiting diarhea bp low potasium low .. inside addison's p
K/c Type DM1

Comm 1
Mnd pt had swallowing problem new diagnosis explain to pt son
Discus possibility of gastrostomy tube

Comm2
a 40 yr old lady referred to opd for loss of appetite ,lethargy. blood tests and usg show CKD ppp0

Explain new diagnosis

Cvs metallic valve replacement
Chest ild
Neuro peripheral neuropathy
Abdomen- renal transplant

[01/07, 12:20 pm] +92 324 0580669: *UK 29.6.24 London Centre*

Communication 1:
Patient with COPD needs to start NIV and patient refusing
Communication 2:
Patient had STEMI and stented previously. Came in with anaemia and need to stop DAP and discuss further management for colonoscopy

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Young lady came in with a collapse, found to be seizure. Has headache
Has abdo pain and diarrhoea for 5 weeks. Had chest infection same around that time.

LCC2:
SOB+Cough

Cardio:Systolic murmur all over the precordium AS

Neuro: facial palsy
Abdomen: kidney transplant
Chest: consolidation

[01/07, 12:20 pm] +92 324 0580669: *UK 30.6.24 Manchester Centre*

Communication 1:
Meningococcal meningitis with sepsis requiring Icu

Communication 2:
Metastatic esophageal cancer for Palliative care

LCC 1
Headache and bodyaches.....GCA

LCC2:
Syncope

Cardio:Systolic murmur all over the precordium AS

Neuro: CMTD

Abdomen: Massive spleenomegaly

Chest: Ild+clubbing

UK centre 9/06/2024

Station 1
Comm: Elderly man came from Australia and developed DVT+PE
Counsel about starting warfarin , pt has CKD
Will ask you can I play golf?

Resp: Elderly with fine B/L crackles > IPF

Station 2
Headache BP 200/110
Middle age lady with know hypertension and not taking her medication regularly

Station 3
Cardio: Metallic mitral valve
Neuro: spastic paraparesis with normal sensations

Station4
Comm: explain diagnosis to a mother of 18 years old, vasovagal attack

Mother concerned it could be epilepsy as she has the same episode when she was young

Abdomen: liver transplant
With Insulin pump

Station 5
Middle age 41 M
Came with recurrent UTI
Has wt loss and father was diagnosed with prostate cancer
Has cervical LN
My friend said couldn't know the case, said most likely resistant UTI
and probably prostate cancer

Examiner prompted 3 times and keep saying common is common

Comm: Elderly man came from Australia and developed DVT+PE
Counsel about starting warfarin , pt has CKD
Will ask you can I play golf?

Station4

Comm: explain diagnosis to a mother of 18 years old, vasovagal attack

Mother concerned it could be epilepsy as she has the same episode when she was young

Comm1- Breaking news MS.
Comm2- patient diagnosed with IBS all imaging and investigation were normal, not improved with medications and dietary advice he had. Unhappy with the diagnosis and wanting a 2nd opinion.

1. ADPKD diagnosis to explain and address concerns
2. Inappropriate cannulation technique . Patient worried about MRSA and wants to complain

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1/24.
****
UK DIET 1 /2024
******
Glangwili hospital,

LCC 1 : Diarrhoea and wt loss in patients with double transplant(kidney and pancreas).

LCC 2: Headache in patients with ADPKD on home haemodialysis.

Cardio : AVR + mid sternotomy scar and Harvesting scar. I'm not sure of diastolic murmur with IE signs.

Neuro- peripheral neuropathy.

Abdo- CLD.

Resp- ? ILD some candidates say bronchiectasis.

****
uk wales 16.3.24
Consultation
Lcc1....Headache ? sah and ? Meningitis..
Lcc2 .... lithium induced Diabetes insipidus

Communication

1. ADPKD diagnosis to explain and address concerns
2. Inappropriate cannulation technique . Patient worried about MRSA and wants to complain

Neuro CMTD

Cvs Systolic murmur in pulmonary area with sternotomy. ? Pulmonary tissue valve

Abdomen
ADPKD and renal transplant.
one scar for renal transplant and one transplant kidney. One more scar in right upper quadrant but I could not feel kidney there.
So I said transplant and then explained fullness in the flank could be due to ADPKD etc etc..
(One girl said there were two transplants). Lady was quite obese.

Resp ILD with clubbing

******
London 17.2.24

Neuro peripheral sensory neuropathy
Cardio Aortic stenosis

Abdomen
Ascitis
Palmer erythema
Rash in face and legs
Said chronic liver disease

Respiratory : lateral thoracotomy scar both sides

Communication Explain diagnosis and discuss anticoagulation
For a patient with recent TIA
after release of his 24 hours holter result
Communication :
Daughter disagreed with the decision of discharging her mother home with community palliative care
Mother COPD on home O2
Currently with chest infection T2RF didn't respond well to NIV
Mother has capacity wants to go home

St 5 *long case*
Young male post road traffic accident
Hx of recurrent collapse with LOC
Family hx sudden cardiac death and epilepsy
No positive finding O/E

(LQT, Brugada, HOCM)

Station 2. Long case

25 years lady referred by her Gp because og episode of lip swelling + SOB after starting interleukin 4
PMH Eczema
Finding : skin rash erythematous ?scaly

****
London 16.3.24
Lcc 1
lady 41yr old hypertensive present with dizziness for 2 years numbness tingling on face trying to get preg went for failed ivf 3 times
D/D conns , RAS (htn in young)

Lcc2 ...
Sudden loss of vision amaurosus fugox

Comm 1
ADPKD counselling

Comm2 ...
Dm admitted with cellulitis with leg Now Cellulitis left arm no MRSA isolated

Resp Ild
Abd ... hepatospleenomegaly
Neuro parkinson
Cvs ....

****
Communication :
1- Discussion with the son regarding his mom who developed steroid induced psychosis for suspected TA , diagnosis excluded by the consultant , steroid stopped mom sent back from rehabilitation .
Son concerns: will she recover totally
When she will be sent for rehabilitation

2. A 37 yrs physiotherapist recently joined the stroke team for the last 3 months admitted with rt sided upper and lower limb weakness , examined by different doctors but the finding are not consistent with each other , CT normal , MR scan done she declined to be informed about the result when the registrar attempt . One of the nurses informed her that the doctors believe that she is faking her symptoms , now she is upset and requested to see u to now about the result and to explain for her her symptoms , the diagnosis made by the team is functional weakness .
Inside she disclosed that she is very stressed at work and at home has financial problems as well .
Concern : _ am I faking my symptoms
_ what you will do for me
_ will this weakness resolve

LCC1 : from outside: pt with breathlessness and swellings in his skin , pulse in AF.

Inside: gentleman with neurofibromatosis with high arched palate
Multiple small scar in chest mainly in middle chest

Will provide u with his drug list which is anti failure med and edoxaban

Concern : for how long i will be on this med

LCC 2 : 57 yrs male sudden onset abnormal sensation on the back of his neck followed by unsteadiness , vision problem and upper lip numbness.

PMH of MI 2 yrs ago , heavy smoker , lorry driver .

Concern: when i can return to work

CVS : dextrocardia
Abd : multiple scar , colostomy bag , IBD
Resp: bronchiectasis
Neuro : MS

****
Neurology:
CMT

Cardiology:
MVR+ A.fib + bilateral leg swelling

Communication
A 45yrs F recently diagnosed T2DM
with High BMI and has had GI side effects on metformin. She currently has osmotic diuresis and blood glucose not well controlled.

Discuss: further management regarding her DM and rationale for her bariatric surgery.

Concerns:
I am frustrated, people are looking down on me

I need bariatric surgery

Comm.2:
Young male px with Ulcerative colitis who doesn't want to start steroids. Discuss Rx options and arrange a mgt plan

Consultation:
80yr Alzheimer with a recent fall (collapse)

3yrs ago had a fall (pacemaker inserted):

PR 50

Has a hx of Hypothyroidism (5yrs + high BP (10yrs)

2 infraclavicular scars

BP: Postural BP drop noticed on examination

On Donepezil Amlodipine, levothyroxine

Consultation 2:
40 year old left arm numbness × 4/7
Has Blurry vision and previous numbness on right side.

High BP
DVLA rules

D/D
: TIA, MS, Migraine, Hypoglycemia,

******
Abdomen multiple abdomen scars and bl nephrectomy scar and intra abdominal device.

Communication 1
Patient was parkinson with pneumonia improved so missed dose of anti park medicines and now drowsy
Concerns like error

Consultation
Ra with joint pain with sob on asking
Pitting edema
Bl crepts / deformities and tendon scars
: patient

Communication 2 pheochromocytoma was the same repeat. Delayed diagnosis

Cvs: avr with MR
Neuro: lmnl swallong difficulty
Fasciculation
Kennedy mnd

Chest. Lat thoracotomy scar with vats or scar probably.
With reduced air entry.

Lcc2: patient young 30 years with high bmi,had endometriosis and checked LFTS and they are raised

1 bottle of wine per week no other risk factor

Do I need admission

NAfld /Nash /alcoholic
Viral as tattoos positive

Differential diagnosis

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Uk diet 1/24

Station 1

Comm:
Myotonia dystrophica counselling.
She had a baby 4 months ago which was diagnosed with MD.
His brother's age is 7 and doing well.
Her mom had cataract at age of 52. She is a symptomatic apart from mild stiffness. Her sister is fine and has 2 kids with no symptoms.

Council and discuss further.
Concern I gave the disease to my children and …

Station 2
Diarrhoea for the last 3 weeks, but vitals are ok.
Inside case of kidney and liver transplant, PN, multiple scars.
Hx of rash & Jaundice.

Coeliac ?

Station 3
Cardio
Device- plus AS.

Neuro
Right foot drop with discrepancy
No scars- no sensory loss

Station 4
Comm;
Hx of tia and AF- given warfarin- stable for 6 years- developed anaemia - treated with iron and improved - further colonoscopy and biopsy confirmed ascending colon cancer-CT CAP was negative

Discuss - refer to surgeon

Concern
- mother died and he will not go for surgery
- stoma
- stroke if stopped warfarin

Chest
Inspirationy crackles likely bronchiectasis

Station 5
Tierdness-fatigue and weight loss

Inside
Lady at age of 70
Lost a stone
Fatigue generally
Appetite is ok
Dysphagia after digging more
Symptoms of myasthenia gravies

No smoking

Hx of hypothyroidism on thyroxin and stable
Ex:
Bilateral sympathectomy scar
Bilateral ptosis
And examination for MG

****____****
: Communication

K/c parkinsons developed pnemonia and admitted in ward and for 3 days now confused and dizzy as anti park medications were missed
Error

Communication 2.
K/c old came with pnemonia already on maximum treatment consultant decided he is already on oxygen n max treatment so tell patient about dnacpr and comfort care
Premorbid he was bed bound at home and max o2 support as well

Lcc1 previous A.spodylitis on mtx came with fever and hemoptysis for 1 month ,father have tb as well

Ddx TB reactivation or any other infection

Lcc2 chest pain 2 episode acute

3/23
******
***DIET 3 2023**
LONDON* UK.

Station 1A
c1 consultation, attending to a 40 years old lady who had a cardio emboli stroke 6 months ago with residual visual deficit . Identified risk factor for the stroke was AF. Now in clinic for follow up, counsel on secondary prevention.

1B was pulmonary fibrosis

2. Clinical consultation with a patient with OSA, HF, HTN (lone examiner and quite difficult)

3 A MVR with rate controlled
3 B Parkinson

4 patient with UGIB wants Discharged Against medical advice because OGD gets postponed

5 Clinical consultation with a 30 years old male patient with travellers malaria. He travelled to Kenya for 1 week, returned 10 days ago. now has fever, joint aches and malaise .

Detailed of the communication stations
Station 1:
Role: Doctor in the stroke clinic
Problem: Discussing Secondary prevention of stroke
Patient: 40 year old Mrs..

A 40-year old lady who had a cardio-embolic occipital stroke 6 months ago with residual eye deficit.
She had various blood tests, carotid doppler and thrombophilia screens done which were all normal. An ECG done revealed **Atrial fibrillation**. She was placed on apixaban, atorvastatin and losartan. She is in clinic today for follow up and will want to have a chat with you regarding her clinical condition, secondary prevention and has some other concerns.

Task: counsel on secondary prevention of stroke and address any other concerns she might have.

Patient's concerns:
How did I get it at a young age?

Can I drive?

Can it recur again?

I forget to take my meds.....

Station 4:
Role: Doctor on ED

Problem: Negotiating with patient that want to self discharged

Patient: A 55 year old Mr X was admitted yesterday on account of hematemesis and melena yesterday following NSAID **abuse** for a bad pain, but he is hemodynamically stable now. He was reviewed by a consultant gastroenterologist yesterday night and booked him for an upper GI endoscopy this morning and advised he stays nil per oral. Unfortunately, his procedure has been cancelled due to an emergency in the endoscopy suite this morning. Patient is angry about the news and wants to self discharge.

Task: to discuss with Mr X of the incident and the need to postpone his endoscopy and negotiate with him not to self discharge.

Concerns:
Why is that? Are you sure it is really an emergency or the patient is a VIP?

Can I self discharge?

Can you assure me that if you find out the reason, I will still be able to get the procedure done today.

How soon can I get the procedure done now?

What happens if I take DAMA?

****
TODAY...UK⚡⚡⚡
Uk

Station 1
Angry daughter; (mom has heart attack and pneumonia)due to admission of other patient who is IV drug user

Chest : left sided **pleural effusion** with right sided **bronchiectasis**

Station 2
Lung transplant, Cushing fancies and back and has infection for the last week

Station 3
CVS: Midline sternotomy scar, lateral thoracotomy scar, AS and metallic sound

Neuro : 3rd cranial nerve palsy but with no mydriasis

Station 4
BBN jaundice, ct showed cancer.
explain and palliative.

Abdomen: kidney transplant and ADPKD.

Station 5
Chest pain, presyncope
B/G SVt with ablation and Ehler Danlos syndrome.

****
ROYAL HOSP UK

Communication
1. A young man being investigated for infectious mononucleosis. CMV, EBV were pending but HIV was positive.
The repeat test showed HIV was negative. His blood was mislabeled with another patient who has HIV.
The consultant had filed an incident report.
Task is to negotiate with patients and make joint decisions regarding the third HIV test.

2. INFECTIVE ENDOCARDITIS FOR IV ANTIBIOTICS NO WAY FOR ORAL PT need TO GO HOME AND HAS FAMILY ISSUES AND JOB

CVS : AVR

CHEST: BRONCHIECTASIS , kartagener syndrome

ABD: RENAL ABD, HAS POLYCYSTIC KIDNEY DISEASE AND TRANSPLANT KIDNEY SCAR AT NECK∆∆I missed case....No AVF, Central cath scar was very faint....Abdomen was huge...missed Scar.

NEURO :
PERIPHERAL SENSORY MOTOR NEUROPATHY
PT HAS A DIALYSIS CATHETER.

CC
64 DM Type 1 POOR CONTROL DM- erratic BS-- GASTROPARESIS AND post kidney TRANSPLANT.

38 yrs
Acute confusion & memory loss for 4hrs.
AND HISTORY OF Headache.

****
Neuro : multiple CN palsies with proptosis

Cardio : MR with AF

Abdo …combined liver pancreas transplant

Chest … scar not sure, very weird scar in front of chest. likely underlying Bronchiectasis.

BCC 1 : myasthenia
BCC 2 : neutropenic sepsis

Communication 1 … counselling to take thyroid medication

Communication 2 … lumbar puncture permission .

Liverpool spine center on 16th November

******
TODAY...UK⚡⚡⚡
Uk

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Abdomen was kidney transplant and PCK

Station 5
Chest pain, presyncope
BG SVt with ablation and Ehler Danlos syndrome

****
Royal hospital
Carousel 3
Comm 1
Persistent hemianopia after stroke in a bus driver counselling regarding driving

Chest

COPD + Left basal crackles not changed with coughing

Long consultation 2
Pruritus after hot baths in 49 male with ADPKD and HTN For 1 month

Inside had a renal transplant
Multiple abdominal scars but not in the RIF.

St3
Cardio AS
Neuro peripheral neuropathy

Comm 2
DNR in extensive AMI with pulmonary edema
Previous 2 strokes
COPD

Abdomen
Bil nephrectomy
AVF working not pricked lately
Tender Renal transplant graft
Tired with spooning of nails and examiners refused to show the mouth as patient wearing mask

Station 5
45 year old male c/o chest pain

Inside : Patient is C/o epigastric pain
Heartburn
Passed one stone in the past
One attack of melena in the past

Father died at age of 50 with heart attack

Diet -3,UK🌊🌊 Liverpool
YESTERDAY🟣
LCC—- 1.Severe headache not responding to painkillers
Aura present, some photophobia,No sings of raised ICP, GCA,no weakness
2. Breathlessness—- 3-4 attacks per year since many years!!!pt with DM1, Bowel surgery at childhood,takes pancreatic enz supplements,Inhaled antibiotic…
Communication—-
1. Dad recurrent fall.. this time no bleeding but confused, Multiple antiHTN , Apixaban due to AF , h/o stroke - 2 yrs back
Consultant altered the medication, discuss about anticoagulant risk & benefit

2. Bronchoscope & Sample taken suspecting TB, Sarcoidosis & Lymphoma!! Bt misplaced & cytology couldn’t be done for malignancy!! Bt tb excluded.. Inform pt about error & tell him he might need to do that again… very angry pt

Cardio - AVR
Resp—- COPD with very small scar may be due to VATS ?
Abdomen— liver transplant
Nuro— SP or Spastic monoparesis

3/23
Paces 23 Edinburgh college UK

Abdomen: RRT and renal transplant

Cardio: Marfan/ AVR and a systolic murmur. a flow or MR ?

Neuro : spastic lower limbs. all viva about parkinsons.

Examination order was to examine both upper and lower limbs.

Resp. Was weezy but with basal fine creps on oxygen.

Said COPD with infection or ILD..

I think they wanted me to add bronchiectasis as a ddx.

Communication1 : BBN of ca pancreas and explain ERCP and palliative chemo

Communication skills 2: SBE, doesn't accept staying in hospital for 6 weeks want to go home because she feels better and has upcoming job promotion

Consultation1: Addison's disease came with infectious gastroenteritis and postural drop.

Missed her medicine and cant take orally

Consultation2 : Takayasu arteritis. arthralgia and wt loss and arm pain.

_****
: Endoscopy postponed in a hemodynamically stable patient who was NPO overnight for emergency of other pt. He was angry and want to go home

Other comm ,,, AF and stroke !
Council him about disease , importance of DOAC , statin and ACEI

3/23

Resp- ILD
CVS- AVR with PPM
Neuro- Unilateral LMNL- Old polio
Abd- Av fistula, ckd on RRT

Long CC-

- Pul embolism,
- Parkinson's disease

COMM- BBN IN A PATIENT WITH CA PANCREAS

COMM2- End of life decision in a patient with multiple Comorbidities who recently had a limb ischemia but was unfit by anaesthesia team for amputation.

UK centre today

2/23

Station 1:

Respiratory-

Elderly lady, on O2, thin skin with bruises suggesting chronic steroid use, fine tremors post left mastectomy, chest examination only had few crepts in left base. I gave DD of COPD on LTOT vs ILD. Discussion was how to evaluate, differentiate between the 2 and if I were to bet on 1 diagnosis what I would say- I said COPD, no rhonchi due to bronchodilator use as evidenced by fine tremors. Got full marks

Abdomen- middle aged man, post liver transplant with no evidence of graft dysfunction/complications of immunosuppression. Questions were 1.etiology for Liver disease- said could be CLD due to viral hepatitis as pt had tattoos 2. Signs of alcoholic liver disease 3. Complications of immunosuppression therapy- got full marks

Station 2:

26/F with palpitations, similar presentation 5 yrs ago, was told to have ectopics at that time. Now has symptoms again, more severe and frequent. Explored detailed history- had family h/o SCD, red flag signs. Discussion was what this could be? Relevance of family history? And features of HCM- clinical/ on echo/ its management- both pharmacological and interventions? Digoxin can be used or not if AF in HCM? – full marks

Station 3:

CVS- 60/M – had high volume pulse with ESM and EDM- said mixed valvular disease, no features of HF/AF/ IE. Asked about pulse? Which lesion is predominant- regurgitation or stenosis? Could it be just AR? Investigations- echo findings in aortic disease? -full marks

CNS- around 60 yr old lady, -Examine lower limbs -findings of predominantly lower limb sensorimotor neuropathy with pes cavus. Asked about DD for sensorimotor neuropathy, management of this case? Curable or not? Got 18/20 – I couldn't complete full examination, as slight confusion regarding equipment to test plantar reflex – some time was lost, so do not make that mistake

Station 4:

Scenario- around 65/F, admitted with fall, diagnosed with Parkinson's few yrs back but started on Rx only in the last few months, symptoms worsening, is confused, being treated for UTI on this admission. Son who lives away has come and is concerned, please speak to him about his mum's condition.

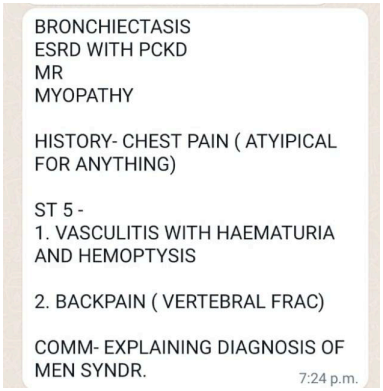
I began with asking what he knew, explained about Parkinson's disease, told that meds control symptoms and improve quality of life only, no prognostic effect, as she was managing well for few yrs, Rx started only when symptoms interfered day to day activities. Explained how disease is progressive- can lead to dementia, however current confusion could be due to UTI, we will have to re-assess after Rx UTI. Enquired about how she is coping/ social aspects/ arranging carer support/ Nursing home stay if disease worsens. Raised advanced planning directive and LPOA topics with son. Discussion was on ethical and medico-legal issues in this case- full marks.

Station 5:

27/M, 2 days diarrhoea, recent UTI, back pain taking tramadol since a yr, no other joint pains and new rash on his chest . Diarrhoea was watery, first episode. Said it could be infective, not suggestive of any other cause as couldn't co-relate rash on chest with diarrhoea- I just said that in celiac rash is DH predominantly on forearms and buttocks, in IBD – PG and EN can be seen, but I don't think its either as diarrhoea is just for last 2 days and pt looks quite well 😊, got 23/28

Case 2:

TIA- explored history, risk factors, quick survey of CN, pronator drift and power in UL, asked pt to walk- but examiner said not required, auscultated heart and carotids. Gave instructions not to drive for 1 month. Discussion was investigations, management, if AF – how will u manage, will admit or not, as this was recurrent TIA I said it's high risk and hence will admit. Got full marks



St 1-
Resp- pulmonary fibrosis, peripheral cyanosis. asked D/D and management.

Abdomen- laparotomy scar with stoma. Is stoma healthy? D/D for indications of surgery how will you manage if he comes with diarrhoea, fever, tenderness?

St2- abdominal pain and vomiting. PMHx of colon ca. Management of ca and D/D

st 3
MVR

Cerebellar ataxia? Head tremor, incoordination,

St 4 pneumatic dil complication- perforation

St 5
BCC1- leg pain while walking better with rest. Smoker, DM, HT, Hyperlipid. PVD and DM(amputated small toe) Limb claudication

BCC2- DM with ketones 2+, PMHx of hypothyroidism, coeliac. plan of management

******
Luton Uk diet 2 2023

Kidney transplant
ILD
MS
Charchot Marie tooth

 Then
St2 MEN 2A

St4 explain mx of chrons to pt

St5 bcc1 pt with disturbances of vision for 3 days , rests are negative.

On exam homonymous hemianopia.

I said stroke PCS or lesion in optic radiation.

Bcc pt with dizziness and cough for 6 weeks. I am not sure about this one.

******
Glasgow Diet 2 /23 today.

Abd: Right iliac and lower midline scar with 2 masses palpable in iliac fossae.
Resp: ILD with deformed fingers

Cardio: Sternotomy scar with systolic murmur in Aortic area.
Neuro: Parkinsons.

History: 28/M with long lasting palpitations and one syncopal episode

Station 4: 91/F got skin cancer. Son has an LPA. Mom has pneumonia and dementia. Son insists on surgery for skin ca.

Bcc1: young female with hemoptysis after vomiting and alcohol intake
Bcc2: will update later.

Cases
1. Resp - pulmonary fibrosis on Ltot
2. IBD + autoimmune ? Scleroderma

3. History - palpitations + tloc
HCM

4. Cardio - absent right radial pulse + prosthetic Aortic valve
I said coarctation + bicuspid AoV
5. Neuro - HSMN

6. Comm skills - dementia Pt

7. BCC1- Headache possible raised ICP
8. BCC2 - DM + TLOC
Not on any anti-diabetics

Glasgow

S1
Female pt chest
rt lat thorac scar + scars for drain
exam : dec air entry, dec VR.

examiner Qs
Findings
DDx
investigation
if she came With fever ?
said infection abscess

abdomen

barely detect splenomegaly
Qs
DDX
How much spleen ?

st
f pt
palpitation
recent delivery
PPT

st3

cvs

mr
midline sternotomy scar
non metallic click
obese
some said assoc As
ddx
Mr
others said Hocm
not quite clear

neuro

LL
bilat spastic paraparesis
hyperreflexia
cerebellar lesion
ddx
inv

St4
UC
result of Bx from colo
go and sit with here
I forget name of pt when I discussed it with her

went good generally

st5
bcc1
chest pain
cardiac in nature

hx of hypothyroid and skin dz
I confabulate and invented PXE
Cvs exam NL

BCC 2
vitals showed
BP 95/62

hx of NAsopha CA
recieved Rtx

dx panhypopit
cardiac
has neck goiter
on arbs ppi and thyrixine
rt armpit lesion
I cooked as PXE puckled skin or chicken apoearance
dicussed risk factors for IHD

Luton UK, diet 2 cases

Kidney transplant
ILD

MS
Charchot Marie tooth

Then

St2 MEN 2A

St4 explain mx of chrons to pt

St5
bcc1: pt with disturbances of vision for 3 days rest is negative on exam homonymous hemianopia I said stroke PCS or lesion in optic radiation.

Bcc2 : pt with dizziness and cough for 6 weeks. I am not sure about this one.

Diet 1 2023 UK

Respiratory: Lobectomy

Abdomen: laparoscopy scars of IBD
History: amaurosis fugax

Communication: angry wife for aspirin allergy which is not true (cardiac rehabilitation after PCI)

Neuro: spastic paraparesis
Cardio: MVR+AF+AR

Station 5/1:

Cough DD: Nitrofurantoin Vs Churg Strauss

Station 5/ 2: normal pressure hydrocephalus

1/23.
Univ crosshouse hosp UK diet 1 23

St 1
Abdo-
ALD - pallor + palmar erythema only
I saw her med - spironolactone
Resp- COPD vs ILD
Was difficult one

St2 - Back pain started today
On Hx- no red flag signs
+ points - wt loss , difficulty initiating urine, also noted some frothing.
DD- Spasm , Vertebral fracture, Myeloma , Prostate Ca

St 3
CVS - tissue AVR + CABG with vein harvesting scar

Neuro - Parkinson

St 4.
Suspected lung Ca on CXR and MRI brain showed cerebellar mets
BBN + counsel about CT chest and Broncho
Went okay . Concerns were not properly dealt

St 5
1. Painful hands from 8 months.
It was Raynaud on BG of Sys sclerosis / CREST

2. Recurrent fatigue and sweating

Difficult Hx with short time
Hx of wt gain + rec hypo episodes

It was insulinoma - I was more of DD- Diabetes , carcinoid etc

At the last minute I told the examiner - it could be insulinoma and the bell rang.

Diet 1 2023
Wansbeck Northumberland, UK.

ILD
AVR sec to Marfans

CLD+HCC
Bell's palsy

Young lady with palpitations (history)

Communication(mental patient with functional dysphagia)

Satiation 5

Thyroid eye disease
PMR, GCA.

Azim vai Carousel :

St 1:
Bronchiectasis

CLD (Ascites + Splenomegaly + Spider+Palmar erythema)

St 2: Raised GGT and AST. Complaint : Mild fatigue. Non alcoholic.

St 3:
Upper limb : MND /CM
AVR

St 4: Vasovagal syncope, wants more investigation

St 5:
Vision problem : DM retinopathy with fundal haemorrhage , patient taking warfarin and on PPM. Needed to perform a fundoscopy.

Weight Gain & Headache :
Acromegaly recurrence.
Past history of pituitary surgery.

Diet 3/22 UK Milton Keynes Hospital

Station 1
Resp - ILD
Abdo - splenomegaly

Station 3
Cardio - Marfan's with metallic AVR and CABG
Neuro - SCA

Station 5
BCC1 migraine
BCC2 post Covid PE

Station 4: anaphylactic shock in a chef with asthma

Station 2 : Kartagener syndrome
———————————————

Diet 3/22 Unknown

Station 4
Bird Fanciers lung

Station5
BCC - 1. Ankylosing spondylitis
BCC- 2. Fever of one day in a CKD Patient

Station 1
Respiratory- Bronchiectasis
Abdomen - Renal Transplant

Station 2
Joint pain , fatigue in 45 year old female

Station 3
CVS - Aortic stenosis vs Aortic sclerosis
Neurology - UMN lesion LL with DCS
———————————————-

Diet 03/22 central middlesex hospital, UK

Station 1
Respiratory - ILD
Abdomen - ADPKD

Station 2
Polycystic kidney disease

Station 3
Cardio - pansystolic murmur VSD MR
Neuro - examine man with tremors

Station 4

Station 5
BCC1 Fever in returning traveller- Malaria

BCC2 headache with paresthesia - Migraine with aura

Royal Albert Edward Infirmary

Station 1 : lung fibrosis
Liver transplant

Station 2 : back pain, Ca: 2.2, ALP : 117

Station 3 :
AVR and mitral regurgitation
Peripheral sensory neuropathy

Station 4 :
DNR and future care plan

Station 5 :

OSA

Loss of consciousness : pheochromocytoma

Uk centre

Abdomen: fistula no scar burns spider navi
I said pt has CKD and on dialysis

Resp: productive cough: copd / bronchiectasis

Hx: eosinophilia with AKI over one month in a 50yr old who takes omeprazole.

Cardio: metallic valve replacement- God knows which one as I said dual valve. No one knew.

Neuro : upperlimb , left cerebellar stroke - examiner prompted me as I was heading elsewhere.

Comm: epileptic lady, seizure free for 8 years. Had arthroscopy and did not take the meds in morning as was advised by docs.and later the pharmacist said she should have taken she had seizure now and cant drive. Was unhappy. Angry and wanted to complain and asked the doc to ask Dvla to let her drive.

Bcc1: swallowing difficulty in a lady with raynaud's- SS

BCC2: A 30 yr old female collapsed - cardiogenic on hx , could be associated to aspirin.

16th November, 2022 cases at James cook hospital :

Station2: type 1 DM lady with high glycated haemoglobin and anaemic referred by GP

Station 4 counsel a patient to start oral steroids due to non response to topical steroids and mesalazine. The patient does not want oral steroids because of side effects.

Station 5A headache and tiredness in 55 year old lady

5B weight loss and cough in 50year old lady

Station 1 Respiratory: I found COPD and the patient had finger clubbing but another candidate said it's ILD.
Abdomen- liver transplant

Station 3 cardio- prosthetic valve
Neuro- charcot Marie tooth

Experience in Glasgow Golden Jubilee center
St 2 ::
Outside 22 yrs old female student with recurrent abdominal pain her vital are normal ultrasound done normal
inside i tell to myself (متسهله شكلها) ???? i ask about about DD that i consider like hereditary angioedema and prophyria and FMF and mesnetric vascular occlusion and i ask specifically about facial swelling she told me yes last 2 day and i ask about all precipitant like pets change environment and cosmetic and food and food allergy hay fever and pollen and ask about stresses in family studying she was so stressed and ask about insect pits and bee sting very important and inhaling any fumes and any part time job and it was shocking for me ??

that she was working as model in make up and
using different creams and i ask about oral
contraceptive pills she was taking and ask
about any medication nil she had surgery for
appendectomy to relief the pain and i ask her
what the comment of the surgeon on the
appendix did u analyze it the examiner was
laughing ???? as i know the case then ask
about family history she was adopted finally wat
ur concern she told me do i need to stop OCP i
tell i appreciate ur concern why ur minded by ocp did u start it recently she told me one year
i
tell her no need at all now and it not the reason
for that she told me so what the reason of my
tummy pain is idiopathic angioedema explain
this unknown decrease in protein that break
down the inflammatory substance leads it to
increase suddenly causing face swelling and
abdominal pain the treatment usually in the
hospital that why u should inform all people
around and keep adrenaline pen with u the
nurse with inform u how to use it is a life
threatening condition if not treated in time
should u continue my part time job
i tell we will do test to exclude that u have
allergy from such substance and we will refer
that to occupational health doctor and if u have
hypersenstivity he will reallocate u accordingly
timeeeeeeee
examiner questions
do u think u convince regarding her job ????
(ده هيستورى مش مرار طافح)
i try my best sir and i will refer her to allergy
clinic for dermal test to see it is releated or not
what if she is free i told she can
continue(????ya lamby)
tell me ur DD
idiopathic angiodema
allergic reaction
wat else (marar tafa7) i tell prophyria he looks
happy ?? (abo shaklak)
then inx and ttt
the bell rang one examiner motivate me and
give me banana ?? i get 20/20
St3::
outside eating banana singing to amr diab walla
be7abek moot relaxing cut thinking.
cardio st patient with headache examine cvs

i see the patient with Midline sternotomy scar
and with harvesting scar with pulse slow rising
with low volume and has metallic 2nd heart
sound all my carousel tell it is not metallic
except me it was really wired and ejection
systolic murmur radiate to neck i finish in less
than 4 min and i take 15 sec to collect the data
then i go to examiner i look to his eye sir i finish
he tell me what i tell the positive sings in a
simple way then the important negatives he told
what is ur diagnosis i tell nonfunction aortic
valve replacement wth stenosis he told are u
sure yes sure sir. what investigation ??? i told i will admit him
now i i will do brain CT scan because of the
headache may be overwarfinized and had brain
hge i should exclude that he give a good smile
then what else i tell echo to exclude IE why u
will do ct head before echo i tell it is more
serious and life saving for time management.
management i tell management of bleeding if
present then go for surgical replacement ask
about u do think this valve not function well i
tell him the murmur is radiating to the neck with
peripheral signs of aortic stenosis
he told me if not fit for surgery what u will do i
tell palliative and end of life care he tell yes then
the other examiner catch my hand and send me
in other bed for neuro st
later i will tell ??? wait us
neuro station unbelievable
instruction examine upper limb only
i get alook to the patient his left food is moving
under bed cover i start examine ul and in fast
way it was completely normal tone power
reflexes (oh shit) i reach cordination it was
normal but slow i realize at that time it is a case
of parkinson i tell the examine can i go to
examin face what u will examin only glabbellar
reflex and belepherospasm it was grabbellar
positive and ask for eye movement no need and then i ask to see lower limb for the
movement i
find tremors in one side and i find apomorphine
syringe like insulin pump i do tone in left ankle
only and bradkinesia and synkinesia all are
positive in left ankle i tell him i want him to write
and ask the patient how u come here negative
both offer gait time finished (horrible)
examiner present ur finding

i tell what i see in organized way
dd parkinson disease
parkinson plus
why r telling parkinson i tell tremors cogwheel rigidity bradykinesia and synkinesia
he told tremor in feet i told can be sir it is regular rhythmic slow with cogwheel rigidity
yes apomorphine pump is effiecent or not i tell him yes efficient with residual tremors and rigidity due to disease progression
he told do think his parkinson controlled i tell i should take history but with physical signs i see it is minor tremors and rigidity so it is controlled
he told will u offer him investigation noooo sir he didnot need
what treatment i told non pharmacological with advance plan care with surgical treatement only
he discuss role of surgery and deep brain stimulation
st4::
a 75yrs old man with cough and heamopytsis since one week admitted in hospital 3 days ago ct scan show a mass and pleural effusion and bronchoscopy showed a cancer, we have talked to the patient about that the patient turkish and know a little english and we use interperter for him and his daughter want to know about his condition tell her about diagnosis and future plan of managment
outside thinking in this strange scenrio ??????
start with asking the daughter about does she take the permission from her father she started to raise her voice and tell me no need for permission i told her it is difficult to complete without his permission
examiner told me assume she has that permission (كنت عايز اخلص هنا واخد اربعه و ال اكلم الوليه المجنونه دى)
i start to break bad news give her water tissue
bad prognosis, he may day with next few weeks or monthes she told me do not tell my father i tell her why she told he is a weak man and he will be depressed i told her we r profession in breaking bad news to hinm and when he find us supporting him beside him ofcourse his agony will be relieved and start to tell her that we know steps of reaction happen after breaking bad news like denial and anger sadness depression

and we can deal with all of that . he has the right to know about his condition and if he has future plan or advanced plan he can do it i think he will satisfied if he did that even the doctor future plan and investigation and he will enter a medical procedure the doctors will tell him later about the reason of such procedure and this break the honesty of medical staff
she stat to be angry again i told he again do u have another reason of not telling him she told me i am the one want to tell to him? i told he i am afraid to tell u this completely forbidden and this our duty and may be ur way will harm him we have the ideal way to do that
then i told her i want to tell u one more thing that i afraid we have already told him? oh my god she tell she become to nervous and hitting the table i react calm with her telling her i appreciate ur way ur caring about ur father but we justify for u the reason of telling is beneficial for him and his best interest for him and we can arrange a meeting with u and him with interpreter to clarify all the things and reply all concerns i tell her about bad prognosis palliative management involving GP macmalian nurse social support and pain management and care of the carer and support
social things
permorbid state
offering help
examiner question was very depressive
first thing he told me did u read scenrio well i tell him yes sir
did u reply her concern well yes sir النعمه و
does the patient has the right to attend meeting of breaking bad news to the patient yes sir after patient permission what if he did not permit her? i will not allow her sir
if she told the patient before medical staff what u will do? i will do my best to correct things and i will explain to the patient with help of the interpreter
for me i think i will get 4 as usual but unexpectedly i got 16 what a mercy from Allah even i see him make negative in one skill and start to frustrate but i find it 16 how come sobhan Allah so people do not frustrate if he comment bad or mark u negative after the

session sometimes he change his view
according to the other examiner

station 5
BCC 1: from outside patient with eosinophilia
5000/ul with joint pains
from outside i tell to myself it is churge strauss
i enter inside i find patient obese only ask about
joint pain 2 month ago it was in right hip and
elbow with hand pain and stiffness with
morning and last 1 hr and ask about weakness i
find there were attack of weakness half the body
no mouth sores she deny any rash although
there a malar flush in here face with cushoiniod
ask about steroid she told me no ask specificaly
about period regular no abortion pills she take
ocp ask about asthma no nasal symptoms no
itching no shortness of breath yes chest pain
no, no headach or blurring of vision or fits or
DVT no hair loss, fatigue all the time with some
weight loss, urinary symptoms nil, no other
medication, she is working as pilot
on examination
hand boutonniere deformity corrected on
making fist and no rayaunds no nodule some
proximal myopathy, chest free heart no need
ask to examine other joint on clothes tell me do
what u can pick up i do only cripitation test what is ur concern what is going wrong i tell her
u have a disease that ur defense system
become maldirected and attacking joint and
lung and cause ur blood more liable to clots like
the weakness u have before we will do scans
and run blood test to prove that for know i will
give some pain killers and refer u to MDT of
joint dr and blood , lung dr physiotherapy and
occupational therapy
2nd concern what disease specifically u can
mark it i tell although it is early to tell except
after run some test but let me share with u the
thinking we suspect SLE with antiphospholipid
and a disease called churge strause
3rd concern do i have allergy because i have
allergy cells in my blood? i tell here this cells
seen in allergy yes but also can be seen in such
diseases i mention before as reaction of
immunity it dose not mean u have allergy and u
didnot have any symptoms of allergy
i ask r u satsifed with my reply to ur concern

she told yes i ask any others concern no
examiner q tough really
ur positive signs i tell deformitiy with correction
jaccouds arthropathy type with proximal
myopathy with malar flush cusnoid face
although no steroid , chest free
ur dd
sle with antiphopholipids
next churge strauss or rhematoid or
microscopic polyangitis or wegners vasculitis
for DD
he ask is there eosinophilia in sle i told him yes
can be especially with antiphospholipid
ask what is the causes of eosinophilia here i tell
may be associated with others condtion like
parasitic infestation or hypereosinophilic
syndrom or the disase itself
he ask about investigation i tell basic & rh ana
anti dna and ANCA P&C anti ccp, coagulation,
lupus anticoagulat and anti cardiolipiden and x
ray chest over hand and affected joints, HRCT,
bone marrow biopsy if all are normal he told yes
managment
no pharamacological
pharamcological if confirmed most of the cause
we give steroid after rheaumatology referral
anticoagulant if APS confirmed
heamologist referral if investigation come
normal
he was happy got 28
all my carousel tell churge strauss and they r
severely deducted play it safe and express
things honestly and logical than u later on other stations stay with us
BCC 2::
a26 yr lady with mild nausea
outside i make dd of local git causes like
gastritis, PUD, non ulcer dyspepsia, hepatitis or
cholecystitis pancreatitis or general cause like
renal failure or increase ICT
inside ask about the nausea in which time it is
more morning she tell me yes at that time i feel i
catch it (ICT) then ask morning headache yes
blurring of vision yes double vision
occasionally happen no the case confirmed ICT
i ask fever neck stiffness or fear from bright
light all no
about wight gain no, OCP yes she told
mouth sores or sores at private area no blood

clots , no dark urine, no lumps or pumps any where no no weakness any parts no fits no loss of sensation no speech problem or gait changes family history mother has a brain tumor before driving yes i tell her stop driving for now and inform dvla
working as teacher
examination i go to eye acuity field movement pupil funds all normal
i do pronotor drift and ask to do planter no need i tell i need to make full neurological examination no need he tell
concern what is going wrong i told u have increase in the pressure inside the brain and the reason may be ur pills that y u shouldn't take for now and i will refer u to women dr to choose another method of contraception and moreover i will do scan for ur head and after we will take a sample of needle from back to measure the pressure i will refer u to brain dr for that
any other concern it can be tumor? i tell no atall u do not have any symptoms of that and the scan of the head will exclude that but i reassure it is very unlikely.
examiner qs
what is ur signs it tells all are negative normal fundus no papilloedema.
what is ur dd
idiopathic intracranial hypertension
any others i tell unlikly to be a brain tumor
i tell because no localizing symptoms like weakness or loss of sensation or dysphesia no other symptoms of malignancy like wight loss or any mass
what investigation i told about brain CT scan
what u expect i tell to be normal what else
lumber puncture what u expect high pressure with normal analysis
what else ? i tell MRV if there is sinus thrombosis he give good smile
how u manage i tell non pharmacological stop OCP
give acetozalmoide and repeated lumber puncture and ventrulopertoneal shunt if need if there is compression on optic nerve we can do optic nerve sheathes fenestration.

station 1 tomorrow
station 1 last station
chest
positive finding
female with very faint mildline sternotomy scar with 4 drainage scars with telengectesia on face and with dilated vein on chest i see tracheostomy scar and 3 cvp scars, trachea central with right zone fine end inspiratory crackles not changed with cough rest of examination normal

what is u dd
i told lung transplant as there steroid cusnoid face he has superior vena cava obstruction but i think it is from multiple cvp canulation after transplant
any others i tell pneunomectomy he feel upset (الحمد هلل على كده) any othersssss???? no sir SVC obstruction not from a cancer i tell yes if cancer there will not be a transplant (he smile)????
he told what is the complication of transplant
i tell him rejection and immunosuppresion drugs abd broncholitis oblitrans then he told broncholitis oblitrans how treated? i tell him it is fatal condition needs icu admission patient stabilization and plus immunosuppressive
what is the investigation to be done
i tell basic invx renal function x ray chest ct scan drug monitoring in every investigation he told me what u well see, i tell free on the side of transplant with pathology in the other side
how u ttt
non pharmacological is very important with rehabilitation program physiotherapy frequently, smoking is forbidden
ttt regular follow up adjusment the dose of immunosuppressive accordingly
abdomen
55 yr old man with Mercedes benz scar with gyncomastia and scar over the Mercedes benz on the right side the patient show me glucometer at the end of examination (و حالل ابن هللا)
what is ur dd
i tell him this a case of liver transplants as evident by mreceds benz scar

what r the dd of mereceds benz scar i told him
liver transplant extensive diaphragmatic surgery
or gastric surgery
what u think why liver transplantation done i
told chronic liver disease as evident by
gyncomastia he told which chronic liver disease
i told him hemochromatosis i suspect because
the liver biopsy scar and glucometer
do u think graft is function i tell yes there is no
astraxsis or jaundice or ascitis
what medication did this patient taking i told
cyclosporin
as he has gum hypertrophy he told me u miss it
i told sorry sir

what the complication of liver transplant
rejection, leak biliary or thrombosis bud chairi,
portal vein, immunosuppression
investigation basic, LFT, coagulation profile ,
albumin and protein, doppler u/s on liver ct scan
if needed drug monitoring
ttt no pharmacological no alcohol
ttt mainly follow up
oh my god finished the exam it is like 2 hour
lost it is seconds
i will share sources and every thing later on

****
UK) Experience
Wrexham hospital

Station 1: Respiratory was pulmonary fibrosis
Abdomen: RIF scar ?renal transplant and
hepatomegaly

Station 2: chest pain and nocturnal reflux
symptoms

Station 3: Cardio: possibly MR or AS
Neuro: lower limb weakness and no sensory deficit ? MND

Station 4: speak to wife of a patient who had a
large stroke, treated with thrombolysis and
developed a large brain haemorrhage. Wife was
angry and this complication wasn't explained to
her and wants to complain.

Station 5: 1st case pt with skin changes and

long standing visual loss ? Pseudoxanthoma elasticum
2nd case: patient with chest pain with recent travel hx from USA and recent cold symptoms. Hx of angina. Had O2 sats of 92%. Differentials ?PE ?pneumonia ?angina

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paces exam experience 29/11/2018 third carousel
UK Dewsbury and District hospital
I started with station 2
20 year old female with skin rash and leucopenia and anaemia
inside i checked history of rash, photosensitive rash started during
her travel and releived by hydrocortisone cream
+ve history of joint pain, mouth ulcers, no genital ulcers, no deformities
+ve history of miscarriage in first trimester
-ve history of mixed connective tissue disease
concern about diagnosis? SLE
what about if i want to be pregnant?
explain flares and some drugs that can not be used in pregnancy
examiner: what is your DD? SLE, what else? antiphospholipid ab, Behcet
and discussion what is with and against
INV? basic and autoimmune profile
ttt? Non Ph and Ph, MDT , he asked about members of MDT
Rh, Nephrologist, Dermatologist, Hematologist, who else Ob/gyn
+ admission, he asked why? because she is neutropenic if after
examining her, there is risk of neutropenic sepsis, she needs admission
U are in the clinic now, you want to talk to anybody before admission? consultant
what simple test to do in the clinic? urine dipstick for proteinuria
I got 20/20
Station 3
Neurology (my weak point)
i missed the case as he was acute patient and in pain
40 year old male c/o difficult walking and using

hands
examiner instructions start UL, if you have time go to face then LL
so i expected Myotonia
very difficult examination, i was surprised he has hypertonia, hyporeflexia
normal sensations, abduction and adduction equal, and the patient has baldness
tenderness in multiple points , weak hand grip, i could not complete the examination
i realized after the exam it is Motor Neuron disease
i got 6/20
cardiology
50 year old female c/o SOB
auscultation Aortic stenosis, with no carotid bruits
examiner: diagnosis, DD, inv, indications of valve replacement
i got 19/20
Station 4
30 year old female known asthmatic, not controlled, recent admission
to ICU with respiratory failure and required intubation and steroid inhaler
was added to her regular medications, still not controlled
tried to explore all the causes of difficult to control asthma
smoking, passive smoking, job, pets,birds,renovation,technique of inhaler drugs,vasculitis,carcinoid, compliance
she is concerned about steroid and is not convinced, non compliant
i explained that inhaled steroid has no systemic side effects and even
if systemic steroids is next step i tried to solve steroid problems
weight,BP,DM,.....
she was difficult surrogate
examiner asked about did you convince her?did u tell her that
the information she is reading in the internet about steroids is wrong?
i got 11/16

Station 5
BCC1 20 year old female with epileptic fits

difficult to control.
spot diagnosis,Tuberous sclerosis,clear
Adenoma sebaceum in face
patient is kind once i asked any other rash showed me ash leef spots
asked about BP and fits and university acheivement
examined face, nails,back , abd and asked for BP, eye
drug list included antiepileptics and Evrolimus
not driving, -ve FH
concern diagnosis and contorl of fits
examiner, diagnosis, name of facial rash
did U ask about FH? yes, did U ask about siblings? no
control of fits? we need imaging to evaluate tubers
kidneys? cysts, angiomyolipoma
ttt MDT
i got 28/28

BCC2: A 79 year old male with blurring of vision

inside unilateral painless transient loss of vision
history of UL and LL weakness but resolved
history of uncontrolled RBS and BP and lipids
No history of HT disease
long drug list but i noticed apixaban
very difficult patient talking very slowly, did not ask all eye questions
i asked snellen chart, they looked for it hahahahahah
then examiner told me normal acuity, field,
patient is not cooperative,
i thought sup quadrantopia but could not say it,
asked for fundus no need
pulse regular, no time for carotid or ht exam
concern diagnosis and time ran out
examiner, diagnosis TIA
what is field defect? he is not cooperative i need to do perimetry
pulse? regular but patient is on anti

1/24
*****
Pune 17th March

1. Communication - mother has CAD and angina refused CABG, son wants to get CABG done by forcing mother to give consent
Resp - bronchiectasis

2. CC - hemetemesis in CLD patient

3. CVS - MVR
CNS - radial nerve palsy

4. Communication - Amiodarone side effect Pulmonary fibrosis, 5 years post MI with VF
Abdomen - renal transplant

5. CC - Young male with Headache/fatigue/Erectile dysfunction - bitemporal hemianopia on examination.

*****
Pune 2nd day

Carousel 3:

1. Respi: ILD
2. Abdomen: splenomegaly
3. Cardio: AS
4. neurology: spastic+ cerebellar
5. Lcc-
A. TIA
B. Liver transplant patient with fatigue, itching, yellow urine
6. Communication - sle renal transplant, mrsa

******
Pune 16.3.24 second carousel

Communications-
Paracetomol overdose asking for discharge
Parkinsons with advanced dementia , nephew asking for feeding options

Abd- liver transplant

Cvs- aortic stenosis and ?diastolic murmur also.

Rs- there was wheeze with crackles- i said bronchiectasis, pulmonary fibrosis and ?copd

Cns- ulnar nerve and ?median nerve palsy with hand wasting

Clinical consultations-
Shoulder pain and stiffness- PMR

Shortness of breath-
There was MR with h/o palpitations

******
Pune 15.3.24
Lcc 1.. AS cardiac syncope sob
O/E ESM

LCC2 ....
difficulty in walking ...
Urinary incontinence ...
O/E dysarthria ... ataxia ..
NPH ... alcohol

Comm1 .
Counsel for the need of Coronary angio cabg stent

Comm2 ...
angry pt with penicillin allergy given by mistake

Resp ...b/l basal inspiratory and exp crepts bronchiectasis

Cardio ...
Midline sternotomy with non cyanosis clubbing + PSM ...
Vsd vs MR/TR / IE

Neuro ...
Command .. upper limb motor examination ...
Left arm umn type weakness
Left leg umn type weakness
It was stroke .

Abd ....
Leukonychia gynacomastia
Spleen ... shifting dullness
Liver span reduced
It was cld

****
Day 1, Pune, Carousel 3

LCC AS with Syncope
Male 70, During work

H/O Heart Sound disorder, miss FU
ESM in Right 2nd space , radiation.
Mild Anaemia
Known DM, on metformin, No Hypo.

CVS AS 35 M DDx HOCM, Bicuspid RHD
Neuro PD DDx Drug Metabolic
Diff between Drug induced idiopathic PD

Commun Af TIA Start Anticoagulant again
He is contraction worker, non compliance to Warfarin for Bleeding

Abdomen ADPKD Inactive AV Fistula Leg edema

LCC : CLD, Hematemesis.
vitally Stable
Ddx : Malory Weiss tear
PUD as on Omeprazol.

Communication- DM Obese start Insulin Driver
Resp COPD IE

******
3/23
******
DIET 3 PUNE INDIA

Abdo station - Liver transplant scar

Respi- ILD with malar rash.

Neuro- Proximal Myopathy

CVS- AS

CC1-? HOCM
CC2- Pituitary adenoma with Bitemporal hemianopia

Comm1- BBN of CT scan of brain showing mets

Comm2- Angry patient with delay in Endoscopy

******
Pune 15.3.24
Lcc 1.. AS cardiac syncope sob
O/E ESM

LCC2 ....
difficulty in walking ...
Urinary incontinence ...
O/E dysarthria ... ataxia ..
NPH ... alcohol

Comm1 .
Counsel for the need of Coronary angio cabg stent

Comm2 ...
angry pt with penicillin allergy given by mistake

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Vsd vs MR/TR / IE

Neuro ...
Command .. upper limb motor examination ...
Left arm umn type weakness
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It was stroke .

Abd ....
Leukonychia gynecomastia
Spleen ... shifting dullness
Liver span reduced
It was CLD

****
Pune day 3 second round
Consult 1 - breathlessness with travel history- PE ,
Consult 2 - LM weight loss, blood in stool - IBD
Com 1 - RA , plan biologic therapy plan, discuss for latent TB
Com 2 - pilot pneumothorax
Abd - splenomegaly
Resp - bronchiectasis
CVS - AS
Neuro - Rt small hand muscle wasting and weakness (? combined median and ulnar palsy)

****
PUNE TODAY♦
Abdomen at
Splenomegaly with hematemesis no sign of cirrhosis

DD was haematological malignancy

Respiratory st : ILD

Neuro
Foot drop without sensory loss
DD could be myopathy

Cardio
Small VSD harsh murmur

Long case :
Marfan with SOB

Communication
Occipital stroke wanted to drive. PT with homonymous hemianopia

Another communication was MND, mode of feeding.

****
. Pune*

Station 1: Motor neurone disease, counsel about peg

Respi : ILD

Station 2.
Tiredness, breathlessness with pallor in a post valve transplant patient.

AF present, anaemic

Cardio : AS
Neuro : Hemiparesis

Comm
Suspected bacterial meningitis, consent for LP

Abdomen
Hepatomegaly in post spelemotimy with jaundice
Hemochromatosis with hemolytic anaemia

*****
Pune exam afternoon session

Consultation 1 - neurofibromatosis.

CVS - MR.
Respi - Pneumonectomy.

Neuro - Parkinson disease.
Abdomen: Splenomegaly, but they asked questions on **transaminitis**.

Consultation 2- syncope AS

Communication- angry relatives. as transgender patient is admitted next to her.

Communication-2nd communication is endocarditis and convinces the patient to stay in hospital for 6 weeks.

*******--
Pune Day 1

CVS- AS
CNS - not sure- LL examination(?Left cerebellar or Lt motor dominant peripheral neuropathy)
Resp - ILD
Abdomen- Renal transplant in LIF

CC1- SOB - Mitral Regurgitation (PSM)

CC2- Abd pain + Melaena + Splenomegaly (COL with PHT, DDx- Myeloproliferative)

Com1- Stroke on Apixaban patient left deficit of homonymous quadrantanopia , so don't allow driving , he was upset about this & explain for other secondary prevention

Com2- Bulbar palsy patient with swallowing difficulties done video fluoroscopy test and explain for further management plan for nutrition.

SQUH
LCC -
1.PCOS weight gain and subfertility
2. TIA (confused by headache probably induced by Amlodipine)

Communication-

1. ICD was deactivated for dermatological procedure and discharged without reactivation- Talk to angry son (Error)

2. Meningococcal meningitis with residual deficits. Talk to the wife regarding the poor prognosis (repeated)

Clinical
Cardio- MVR (I think 🧐)
Neuro - Cerebellar Syndrome, Young man probably degenerative disease
Abdo- KT in LIF with joystick scar in right

Chest- For me Bronchiectasis but I am also not confident

Exam today

Neuro. Spastic paraparesis with spinal level

Cardio dextrocardia with AS

ABDO hepatomegaly with spider naevi DDX CLD and causes

Lungs pneumonectomy/ lobectomy with underlying bronchiectasis

LCC 1 backpain 2/52 hx, previous hx of prostate ca, concern was about osteoporosis and prolapsed disc

LCC2 Takayasu arteritis but hx and clinical examination was entirely on proximal myopathy secondary to some herbal medications, some cushingoid features but on examination it was written on the wall that pulses and B.p was unrecordable

Communication 1: latent TB

Communication2: endobronchial biopsy for lymphoma was lost, admit error and convince to have it again.

Communication
1.
Endoscopy postponed angry patient(we did it last day)

Respiratory -Bronchiectasis

2.LCC:
Systemic sclerosis with Pulmonary fibrosis
SOB was the scenario.

3.CVS :MVR

CNS :There is a dorsal column sign with plantar extensor. Put d/d :multiple sclerosis.

4.communication:
Son with RTA ,Rehabilitation for 5 months. No improvement.

Consultant plan for home discharge with all support But mother don't agree.

Abdomen :Splenomegaly

5.LCC:
Headache
Tired

Muscle cramp
Polyuria
Hypertension

Dd :

Conns
Pheochromocytoma

Viva was about conns

******
Station 1
Communication
40 year old MND pt
Explain natural progression of disease , need of RIG PEG NIV..
(Pt highly depressed , not looking to eyes , head down full time)

Resp - ILD

Station 2
Post mitral valvotomy followed by MVR recently with exertional breathlessness (no orthopnea PND)and occasional palpitations for last 4 months.
O/E. AF MVR click

Station 3
CVS - A.S
Neuro - hemiplegia

Station 4
Pt with meningitis, convince for LP

ABDOMEN - Anaemia , jaundice, post splenectomy scar.
D.D - haemolytic anaemia

station 5
Post liver transplant with fatigue , loss of appetite, nausea. Stopped all medicines last 1 month.
D.D Rejection / infection..
[11/12, 9:15 pm] +971 55 369 4919: My LCC and communication stations were fine I feel...

CVS station
I said MR Coz I got radiation to axilla and patient was young.

there was systolic murmur in aorta also but couldn't appreciate radiation to carotid
[11/12, 9:15 pm] +971 55 369 4919: Convince for LP for meningitis pt

40 yr old MND explain natural progression of disease, RIG ,PEG ,NIV

[11/12, 9:15 pm] +971 55 369 4919: Actually case was AS

Qatar

2/24

Doha diet 2 *7.7.24*

comm 1
DM admitted with limb ischemia, talk to him regarding non-compliance and lifestyle.

comm 2 medical error

Chest young female with lung fibrosis
Cvs young male AR+Ms
Neuro Lt flacid paraparesis, with UMN signs on Rt LL?

LCC 1
lady with B/L weakness, inside Cushing on peritoneal dialysis

LCC2
headache inside acromegaly

Doha 1/23

St 4
a 37 yr old lady known to have psoriasis ,and psoriatic arthritis has been on methotrexate since 3 yrs . Before 3 days had UTI and was given trimethoprim developed pancytopenia today her cbc shows pancytopenia hb 9 wbc 1.1 plts 30.
My Task is to explain to her what happened and discuss a plan

History station:
Mr.X is a 50 yr old male has had dizziness for 3 days and chest pain .
Hx of MI 6 weeks ago .

BCC1 Mr.Y 41 yr old has persistent HTN .
Asymptomatic .

BCC2 .Mr.NJ 40 years old has had double vision for a few days .

Abdomen splenomegaly

Respiratory bronchiectasis , figured out dextrocardia at the last minute!

Neuro peripheral neuropathy

And cardio not sure what was the murmur

Doha 10-02-23

BBC-1 Fatigue and daytime sleepiness- acromegaly +osa

BCC2- Diarrhoea bloody with joint pain in young man with appendectomy scar-? Crohn

ST 4 palliative care with advanced COPD and type 2 DM with empyema and sepsis

ST 2- young female with diarrhoea for 3 months.

Hx of travel with Thailand 3 and 1/2 months back. Stool - watery and semi solid

ST 1- renal transplant
Bronchiectasis

ST 3
Metallic click with scar in leg
Pure motor flaccid paraparesis

Diet 3 , Rawalpindi Day 1 : morning

Cardio …..AR.

Abdomen….Liver transplant,

Chest….thoracotomy,

Neuro… lmn lesion,

cirrhosis (consult),

Scleroderma (consult)

Compiled By Dr Hassan Mehmood
MBBS, MRCP UK

+923277975723

Communication, 1. Patient of infective endocarditis, wants to go home, u have to convince him to stay in hospital for iv antibiotics

Communication 2, patient of bulbar palsy, have recurrent aspiration, one test that is video fluoroscopy has done, u have to tell about the video fluoroscopy result and tell him other methods of nutrition i.e NG tube and PEG

DIET 3 2023 RAWALPINDI PAK

Clinical consulation 1 Alkolysying spondilistis

LCC 2 heart failure

Communication

1-UC steroid induce avasucular necrosis

2. bisphosphate induced gastric ulcer Talk to patient

resp –bronchectasis

Abd-renal transplant

Cardio MR –vsd

Neuro myasthenia

DIET-3 RAWALPANDI

Comm: 1- 72 yrs old came with stroke, thrombolysis given after consent by patient, pt had massive ICH, GCS: 3, neurosurgeons said he's unfit for surgery, counsel son he's going to die soon. Son is asking why wasnt he informed and asked before thrombolysis.

Comm : 2- young female came with fever, headache, photophobia, skin rash. U r suspecting meningitis, Explain your suspicion and counsel for LP.

Resp: Bronchiectasis with lower lobectomy

CVS: MR Abdomen:

Renal transplant with pain abdomen (was asking for cause)

CNS: asymetrical Spastic paraperesis, clonus, sensations intact

Consults:1- middle age man with nose bleed. On history no bleed from anywhere else, pt has cough at times productive, no renal symptoms. On ATT for a few months but noncompliant. On exam, saddle nose and crackles on chest exam. Made GPA my first D/D, then TB.

Consult 2. Young male with 1 month h/o fever and cough mostly dry. O/E, fever, HR 100/min, Resp rate: 20, BP: 100/60.Treated for Pulm TB 2 years ago.History- recent travel to Punjab, no other info known by the surrogate High risk behaviour before- 2 casual partners plus IV drug abuse in past.O/E: wasted, had coarse crackles on chest exam.D/Ds I gave were:- HIV with PCP- Reactivation of TB- infective endocarditis

Diet 3 Rawalpindi 2023

Lcc 1: Bleeding per rectum Inside acromegaly.

Lcc 2: Sob and cough 6mnths Wtloss 6kgsClubbing Yellow sputum Ps: clubbing ,Palmer erythema,flapping tremers,coarse crepts in lungDdx ca lung/ bronchiactasis ild/ copd

Communication 1, patient came with heart attack done PCI ,during that undergone cardiac arrest and diet bbn to wife

Comm 2, patient has got suspension of lung ca bbn and tell abt ct and further mgt.

Chest lobectomy

Cvs MR

Neuro ulnar nerve palsy

Abdo renal transplantation

islamabad day 1 21.5.24 diet 2

Lcc1 sob fatigue Black stools malena Backpain stiffness Dx ibuprofen biologics Px Ankylosing spondylitis Lcc2 left arm weakness 2 month then right arm gradual onset Examination Lt arm wasting flaccid and facilitation Ddx mnd

Cardio MR

Neuro. Facial nerve palsy

Communication 1 Patient developed left leg pain and diagnosed as DVT So discuss diagnosis and treatment Communication

Comm 2 Young man diagnosed with hypertension and was pit on anti hypertensive medications now counsel about disease and treatment and lifestyle modifications

Rwp evening cases 21/05/24STATION

LCC 1: PT OF ACUTE EXACERBATION OF COPD ON THEOPHYLLINE STARTED THIS TIME ON CLARITHROMYCIN DEVELOPD SEIZURES.....DRUG DRUG INTERACTION.

2LCC : CONGESTIVE CARDIAC FAILURE

Resp.: ASTHMA/COPD

Cardio: AS+AR

Abdomen: NEPHRECTOMY

Compiled By Dr Hassan Mehmood

MBBS, MRCP UK

+923277975723

COMMUNICATION 1: PATIENT K/C HTN ON ACEI +NSAIDS FOR BONY PAINS DEVELOPED ARF DUE TO DEHYDRATION.COUNSEL FOR HEMODIALYSIS 5LCDCHRONIC PANCREATITIS.

Rawalpindi 22.5.24 diet 2

LCC 1: 66 yrs with headache from 3 months with episodes of anxiety Vitals normal.(Surrogates mention that he was HTN and hypothyroid) BP was 110/70

LCC 2: Progressive lower limb weakness from 1 year Age 39,Vitals N, no previous comorbid MND .

Cardio: AS

Neuro: was it young man with horizontal nystagmus Command examine cranial nerves. Rest were normal and i didnt found any cerebellar lesion

Abdo: Palor,, half and half nail with normal liver span but splenomegaly and shifting dullnessI made it CLD

Communication 1: Young lady with joint pain fatigues, herself concern was lupus, but all blood test and imaging of joints were normal. Task was to talk to her

Rwp evening 23.5.24 diet 2

LCC1 : hyperthyroid

Lcc2 : vomiting sec to nsaid induced gastritis or theophylline toxicity

Communication: 1 ulcertive colitis explain dis and management

Comm 2 : Pneumothorax explain dis and management

Chest: IPF

Neuro stroke

Abd viral hepatitis

Cardio AR

Rawalpindi cases today 24th May

Comm1: open TB case, wants to get discharged n see her mother in another country who recently suffered from stroke. Task: Explain the risk of spread of infection to others

Comm2: Fibromyalgia,, Task: Explain that no further investigations will be done

LCC1: RA with 2 day h/o cough n sob,, ex smoker,, h/o long flight to Australia 2 weeks ago n family h/o thromboembolism

LCC 2 Headache,, Migraine

Chest,, asthma

Neuro,, MS / transverse myelitis

Abdomen,, HSM with jaundice

Cvs,, AS

Rwp 25.5.24 .diet 2

LCC 1:Fever for 5 months along with blood thru back passage.. blood with stools and sometimes blood without stools No history of loose motions, hx of contact with unpasteurised milk, history of intake of antibiotics 5 months back at the start of this fever... took azithro and cipro for 2 weeks, wt loss of 10kg in last 4 months, no other source of infection, no contact with HIV or TB person, I examined abdomen, chest and hands, face. No positive finding. Forgot to check lymph nodes. I made DDs of CA colon Pseudomembranous colitis Brucellosis

LCC 2 Sob Cough Patient had ILD Communication

1:Ulcerative colitis leading to high grade dysplasia Break bad news and counsel about proctocolectomy drew for the patient and told in detail, told about colostomy bag and Fups and occupational and financial support as well

Comm 2:NAFLD Counsel about lifestyle changes.

Cardio: AS (some were saying AS with AR, I only found AS)

Neuro: Flaccid paraparesis, no sensory abnormality, both sensations intact I did not find wasting.I gave DDs of GBS CIDP Periodic paralysis

Abdomen: Anemia plus spleen DDs Hematological malignancy Hemolytic anemia

Resp Patient had wheeze and creptsILD / bronchiectasis

Rwp morning 23/01/24

Cardio..... Mitral stenosis

Resp....scar with effusion

NEURo.... pure motor neuropathy GBS

Abd..... jaundice with hepatosplenomegaly

Consultation 1...

Shortness of breath in male patient with high BP in vitals outside 180/110

Significant hx of DM HTN and asthma on steroids significant family history if stroke and high bp

Ddx

OSA sec to cushing

cardiogenic asthma

Metabolic syndrome

Consultation 2..

Weakness of all 4 limbs

Surrogate told about progressive weakness with fasciculations

Inside MND

Communication 1...

Scnerio of DM with hypoglycemic unawareness on bisoprolol as well

Communication 2...

Pckd bbn and further plan

Pakistan evening 23 jan diet 1/24

Cns: MS

Pulmo: Copd

Abd: hepatospleenomegaly

Cvs: valve replacement with MR

(Not sure MVR or AVR)

Consultation:

Parkinsons

Tuberculous meningitis (hiv patient)

Communication:

Hep. B scenario

Pakistan evening 23 jan diet 1/24

Cns: MS

Pulmo: Copd

Abd: hepatospleenomegaly

Cvs: valve replacement with MR

(Not sure MVR or AVR)

Consultation:

Parkinsons

Tuberculous meningitis (hiv patient)

Communication:

Hep. B scenario

Pakistan morning 23/01/24

Cardio..... Mitral stenosis

Resp....scar with effusion

NEURo.... pure motor neuropathy GBS

Abd..... jaundice with hepatosplenomegaly

Consultation 1...

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Significant hx of DM HTN and asthma on steroids significant family history if stroke and high bp

Ddx

OSA sec to cushing

cardiogenic asthma

Metabolic syndrome

Consultation 2..

Weakness of all 4 limbs

Surrogate told about progressive weakness with fasciculations

Inside MND

Communication 1...

Scnerio of DM with hypoglycemic unawareness on bisoprolol as well

Communication 2...

Pckd bbn and further plan

Pakistan morning 24th jan 24

Communication 1

Leg Cellulitis was treated in hospital with iv abx

Junior dr changed iv cannula with out gloves n he got MRSA infection in arm as well

So dealing angry patient

Communication 2

Young lady took gliclazide

Was managed with dextrose

Mx team decided to take mood dr review for her

She was angry n was will DAMA as mood dr was involved without her consent

Bcc 1 CABG 7 years back

Recurrent epigastric pain since few months

Dx is chronic pancreatitis alcohol n TG

BCC 2 weakness

Dx MCTD

NEURO Prox myopathy

CVS MR with fine crackles

Chest ILD with Rh arthritis

Abdomen

Right sided burn like scar with no mass beneath it but left sided Nephrectomy scar n avf in left hand

Pakistan 24.1.24

Abdomen..LT

Respiratory..lobectomy/Pneumonectomy

Short case neuro...LMN signs: MG with Thymectomy scar

command was upper limb and it was proximal myopathy pt was having CVP line in Neck he was myasthenia gravis patient middle age patient wid no thymoma scar.

CVS : HOCM

communication 1...APKD

Communication. 2....Angry patient :son was concerned regarding steriod induced psychosis ie steriods was given in suspicion of GCA...Howerever the consultant proven that its not the diagnosis and pt was stopped from steriod and the admitted to the hospital.

Consultation scenarios

dysphagia.

COPD with pulmonary hypertension.

Pakistan 24.1.24

Commu- son of a PT who has bladder CA now presented in ER with drowsiness and deranged Rfts, treatment nephrotomy planned

Commun- angry daughter whose father developed amiodarone ass lung fibrosis

Neuro - left hemiparesis with left UMN facial nerve

Abd- ESRD with Renal transplant and fine tremors

Resp scar with pneumonectomy /lobectomy

cVS - MVR with systolic kurmur

BCC- progressive weakness -inside MS in a PT who has ataxic gait , INo and past pointing

BCC- - backache that gets worse with rest , inside psoriatic arthritis

Pakistan morning diet 1 26.1.24

Comm

Penicillin allergic given penicillin and now she has pnemonia diliruim and error

Abdo. Pckd bl balotable mass.fistula with recent needling in HD bruising whole body

Lcc

Hx of RA young swelling in lt knee

Excluded Reactive arthritis/septic also

Ra

Lcc2

2 days fever back now fine .hx of neck pain no stiffness

1 day hx unable to close eye

Lmnl facial palcy

Ex. Not febrile traveled to US few days back.

Fever high grade took pcm resolved

Lyme disease may be

Fx father have weakness of arm and legs like ms

Concern . Is it going to die ?

Is going to be better

Chest dec breathsound lower rt chest over with treachery shift to affectide side

Comm2:

Medication error

Known dM came in ward with pnemonia .dr proscribe…

Islamabad 27-01-24

LCC1

young male with LOSS OF CONSCIOUSNESS

hx of Vasovagal syncope

LCC 2

Pain in Right Hypochondrium

Cholangioca

Abdominal

Hepatomegaly with jaundice

CVS

MITRAL STENOSIS with PH

RESP

consolidation with effusion

CNS

MULTIPLE SCLEROSIS

Communication

1- Uncontrolled Diabetes not willing to take Insulin injection

2- 78 years female with CAD Hx now Angina at rest, CABG planned and patient refused for it as explained by the interpreter

Son insisting on signing the consent and asking if he can explain this to the patient about instead of interpreter and was angry why we talked to the patient about surgery without involving him first.

Rwp center 23/05/2024

Morning cases

Comm 1: young female had normal SVD of a healthy son, diagnosed to have Group B streptococcal based on isolation from vaginal swab. So to prevent child getting infection during delivery and as part of standard treatment she was given Penicillin IV, on the 3rd day the mother reacted with rashes on the face and body and she was diagnosed to have SJS with multiple organ insufficiency involving the Kidney and the Liver (deranged LFT, RFT). Now she become confused requires ICU transfer and possible intubation.

Explain to husband

Cvs: MR

Abdomen: renal transplant

lcc1: hypothyroidism

Lcc2: recurrent pulmonary embolism due to DVT, likely secondary to thromboplilia (mother had died of clots).

Comm 2: diabetic female , non compliant to insulin, developed proteinuria. Also has high BP with retinopathy. ACEi started but GP worried she would remain noncompliant. Explain proteinuria with stress on compliance.